SURVIVING INNER-CITY WAR ZONES:

TRAUMA AND RESILIENCY AMONG URBAN YOUTH EXPOSED TO COMMUNITY VIOLENCE

By

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CERTIFICATE OF APPROVAL

I certify that I have read SURVIVING INNER-CITY WAR ZONES: TRAUMA AND RESILIENCY AMONG URBAN ADOLESCENTS EXPOSED TO COMMUNITY VIOLENCE by Mark C. Purcell, and that in my opinion this work meets the criteria for approving a dissertation submitted in partial fulfillment of the requirements for Doctor of Psychology in the Clinical Psychology Program at the California Institute of Integral Studies.

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ABSTRACT

This study examines the effects of community violence exposure upon trauma and resiliency-related process among inner-city youth. A mixed-method design was applied with a sample of twelve youth ages twelve to eighteen. Standardized instruments were used to assess levels of community violence exposure, and posttraumatic symptoms and diagnoses. Semi-structured interviews were conducted to gather qualitative data pertaining to trauma and resiliency-related processes, as well as subjects' perspectives on youth violence and recommendations.

The quantitative results indicated that the youth studied were exposed to high rates of community violence. PTSD assessments indicated that ten of the twelve youth (84%), met diagnostic criteria for PTSD, with eight of the Chronic PTSD Type, and two of the Acute Type. The most

common symptom cluster endorsed by the subjects related to re-experiencing symptoms of the PTSD spectrum. Many youth also reported symptoms of complex trauma, such as affective dysregulation and aggression. Qualitative analysis of the data involved individual case studies based upon dominant categories, followed by cross-case analysis of common themes. Factors which influenced posttraumatic response were: exposure type and severity; relationship to the victim; and internal resiliency as well as external sources of support.

Youth who experienced more trauma-related distress, and who engaged in a process of searching for meaning, reported positive growth and change following trauma exposure. High-risk youth involved in violence-related activities reported less distress although they often had significant PTSD symptoms. High risk youth often did not share their traumatic experiences and had few intimate social supports. Resilient youth coped through self-reflective activities such as creative writing and art. These youth also tended to have more intimate relationships with peers, family, or adult confidants. Causes for youth violence proposed by subjects were oppressive life circumstances and negative self-concepts among violent youth. Recommendations for dealing with youth violence

were increased youth programs and opportunities for underprivileged inner-city youth.

Integrated analysis of the data determined distinct processes related to community violence. The path of resiliency tended to lead youth towards trauma recovery; while the other risk-oriented path tended to lead towards complex trauma and increased violence involvement.

DEDICATION

This dissertation is dedicated to all of the children in the world who must struggle to receive the natural gifts of childhood: to be safe and protected; to be curious and industrious; to laugh and play; and, to belong and feel loved.

"If we are to reach real peace in this world... we shall have to begin with children." - Mahatma Gandhi

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TABLE OF CONTENTS

Abstract.......... iv

Dedication vii

Acknowledgments viii

List of Tables xvii

Chapter One: Introduction 1

Chapter Two: Literature Review 6

Community Violence 6

Prevalence & Predictors of Youth Exposure to Community Violence 8

Early Studies on Community Violence 8

Prevalence Rates of Exposure to Community Violence 10

Predictors of Exposure to Community Violence 15

The Detrimental Effects of Chronic Community Violence 19

Aggression and Violence among Inner-City Youth 23

Theories of the Development of Violence and Aggression 24

Psychosocial Factors Contributing to Youth Violence 26

Socio-cultural Inequities Contributing to Violence among Minority Youth 31

Trauma 36

Trauma Defined 36

Variations of Traumatic Response and Related Syndromes 40

The Psychobiology of Trauma 44
The Biology of Trauma 44
Loss of Stimulus Discrimination 46
Self-Regulation & Integration Difficulties 47
Attachment Theory & Interpersonal Aspects of Trauma 50
Traumatic Reactions of Children & Adolescents 52
Early Studies on Childhood Trauma 52
Exposure to Violence and PTSD 56
PTSD in Children and Adolescents: Diagnosis and Clinical Presentation 60
PTSD Symptoms and Developmental Variations 63
Long-Term Effects of Childhood Trauma 65
Chronic Community Violence and PTSD 67
Urban Violence Traumatic Stress Response Syndrome (U-VTS) 71
PTSD Symptom Profile Caused by Chronic Community Violence 75
Chronic Violence, Complex Trauma and Intergenerational Trauma 81
Resiliency & Survival 87
Youth Resiliency & Protective Factors 87
Early Studies on Resiliency 87
Internal Assets & Characteristics of Resilient Youth 90

External Assets & Environmental Protective Factors 91

Resilience & Protective Factors among Youth from Violent Communities 96

Internal Assets & Personality Characteristics 96

External Assets & Environmental Protective Factors 99

Positive Growth Following Trauma 105

Predictors of Positive Growth Following Community Violence Exposure 109

Chapter Three: Research Question & Rationale 112

Chapter Four: Methodology 116

Study Sample 124

Procedures for Data Collection 127

Assessment Instruments: Measures & Procedures 129

Survey of Children's Exposure to Community Violence 129

Children's PTSD Inventory 130

Semi-Structured Interview 131

Data Collection and Analysis 132

Chapter Five: Results 138

Quantitative Results: Summary of Assessments & Surveys 138

Rates of Exposure to Community Violence 139

PTSD Diagnoses & Symptoms 142

Qualitative Results: Individual Case Summaries 146
Exposure Level One: Vicarious Traumatization 148
Jordan 148
Tamika 161
Exposure Level Two: Witnesses of Community Violence 168
Tonia 168
Yvonne 180
Exposure Level Three: Direct Victims of Violence 195
David 195
Cynthia 205
Exposure Level Four: Victims and Perpetrators of Community Violence 217
Trevon 217
Raheem 240
Qualitative Results II: Cross-Case Analysis of Categories 259
Environment 259
Demographics 260
Community Violence 260
Critical & Traumatic Event(s) 263
Perceived Threat 264
Vicarious Traumatization 265
Witnesses: Trauma to Others 266

Victims: Trauma to Self 267

Subjective Experience of Severity 269

Relationship to Victim 271

Grief & Loss 271

Severity of Traumatic Reaction and Relationship to Victim 272

Diagnoses & Trauma-Related Symptoms 274

PTSD Diagnoses 275

Re-experiencing Symptoms 276

Avoidance & Numbing 277

Increased Arousal 278

Related Symptoms & Diagnoses 279

Complex Posttraumatic Stress Syndrome 280

Dynamics of Violence 284

Affective Dysregulation 284

Aggression 285

Code of Conduct within Urban Youth Subculture 287

Masculine Roles among Urban Youth 288

Socio-Economic Inequities and Related Hostility & Despair289

Risk Factors 291

High Violence Environment 291

Negative Peer Affiliation 292

Criminal Activity 293

Substance Abuse 293
Family Conflict 294
School Difficulties 295
Protective Factors 296
Family 296
Adult Confidants 298
Peer Support & Intimate Partners 300
Community Resources: School & Community-Based Programs 301
Mental Health Professionals 302
Resiliency 303
Creative Expression 303
Self-Esteem & Positive Life Choices 305
Making Meaning 306
Trauma as Catalyst for Change and Positive Growth 306
Spirituality & Fate 308
Causes of Youth Violence 309
Negative Life Circumstances and Poor Self-Concept 310
Peer Conflicts 310
Weapons 311
Recommendations 312
Increased Youth Programs 312

Opportunities 313
Additional Themes and Patterns of Qualitative Data 314
Gender Differences 314
Age Differences 315
Cultural Factors 316
Integrated Analysis and Emergent Theory 318
Pathways of Resiliency & Risk in Response to Community Violence 319
Stage I: Chronic Violence Exposure 323
Stage II: Critical Incident 324
Stage III: Internal Response 327
Stage IV: Social Interaction 330
Stage V: Future Orientation 333
Chapter Six: Discussion 336
Clinical Implications 345
Recommendations for Future Research 356
Conclusion 359
References 360
Appendix A: Parent & Participant Consent Forms 385
Appendix B: Semi-Stuctured Interview 389
Appendix C: Sample Interview Transcript 390

LIST OF TABLES

Table 1: Disorders of Extreme Stress Not Otherwise Specified (DESNOS) Proposed Criteria 42

Table 2: Demographics of Sample Study 126

Table 3: Rates of Exposure to Community Violence 140

Table 4: PTSD Diagnoses & Symptoms 144

Table 5: Pathways of Resilience & Risk in Response to Community Violence 321

CHAPTER ONE: INTRODUCTION

Community violence has become a societal epidemic in the United States, with youth suffering its most lethal and devastating consequences. The violence which many inner-city youth cope with is chronic, severe, and pervasive. This constant insidious threat has been demonstrated to negatively impact youth across multiple domains of functioning. An alarming proportion of inner-city youth exhibit clinically significant symptoms of posttraumatic stress, depression, and anxiety. Despite these seemingly insurmountable odds, many inner-city youth go on to lead meaningful and successful lives. Amidst the myriad risks in their lives, certain youth have demonstrated incredible resiliency. It has been demonstrated that high risk inner-city youth can survive the urban war zones in which they live. This study will involve an in depth exploration of the ways urban youth are affected by community violence, and their sources of resiliency.

Community violence is most rampant in inner-city neighborhoods, often inhabited by low income, minority families. Violence has become the leading cause of death among certain ethnic minority adolescent populations. Numerous studies indicate that ethnic minority youth from

inner-city neighborhoods and schools are victims of disproportionately higher levels of violence than their White counterparts. The fortunate urban youth who are not directly victimized, must endure the multiple forms of violence which plague their schools, communities, and frequently, their homes. In many inner-city neighborhoods, it is common for children to hear gun shots on a daily basis, have a close friend or family member murdered, or be direct victims of violent acts ranging from physical assault to rape and shootings. Some researchers have referred to inner-city communities as "war zones" comparing the toll violence has taken to other war-stricken countries (Bell & Jenkins, 1993). The consequences for youth have been devastating, impacting multiple domains of functioning. As a result of the damage caused by community violence, it has been identified as one of America's leading health concerns for its youth.

The prevalence of violence appears to be perpetuated by a viscous cycle, whereby, victims of violence often become perpetrators. Consequently, inner-city youth are both the greatest victims of community violence and its worst perpetrators. Experts from various fields of psychology and sociology have posited explanations for community

violence. There appear to be multivariate factors ranging from individual and familial differences to socioeconomic influences such as poverty and inequalities between ethnic minority groups and mainstream America. The first section of the literature review will present the research findings related to the psychological effects of community violence, followed by an examination of research pertaining to the evolution of youth violence.

Clinically significant symptoms associated with community violence include: trauma, depression, anxiety; as well as, conduct, dissociative, and personality disorders. Posttraumatic stress disorder has been identified as one of the most common psychological disorders associated with community violence. Recent research indicates that trauma is a complex psycho-physiological disorder which may be more complicated than current diagnostic criteria. The second section of the literature review will focus upon trauma and the unique ways it impacts children and adolescents. Special attention will be paid to research on traumatic responses to community violence.

Many youth manage to lead healthy successful lives in spite of growing up in neighborhoods riddled with violence and depravity. Amazed by this resilient capacity, previous researchers have studied the

protective factors which foster resiliency in youth. They have identified certain internal and external assets which interact to help children cope and develop in the face of adversity. The third topical literature review will present findings of research on resiliency. Studies addressing the resilient qualities among youth exposed to community violence will be examined in depth.

The breadth of topics intricately related to community violence indicates the complexity of this social phenomenon. The research design used in this study attempted to address some of these interrelated areas of inquiry. A mixed method approach was used, as it has been recommended when addressing a problem that is present in a complex social context (Tashakkori & Teddlie, 2003). The study consisted of a collective (multiple) case study design. This research design allows the researcher to compare data and themes across cases, while maintaining case-specific details.

Twelve youth, ages 12-18 years-old, who have been exposed to varying degrees of community violence, participated in the study. The study sample was mixed gender with half female and half male respondents. The study sample had a heterogeneous ethnic background.

The diversification of the study sample was intended to provide the maximum variation in experiences and perspectives pertaining to community violence. A combination of standardized assessments and surveys – instruments measuring exposure to community violence and trauma-related symptoms and diagnoses – and semi structured interviews were used to gather data.

The central question this research study addressed was: "How does community violence effect urban youth; and, what are the resources which help youth cope and survive?" The four research topics which were examined in relation to this question are: (1) Levels of exposure to community violence; (2) Trauma-related factors, including diagnoses and symptoms; (3) Resilient qualities which help urban youth cope (individual and environmental); and, (4) The interaction between community violence and processes of risk and resiliency.

The literature review sections which follow will examine research pertaining to these domains.

CHAPTER TWO: LITERATURE REVIEW

Community Violence

Although the average American adult has experienced a relative decline in violence victimization rates since it peak in the early 1990's, youth homicide rates remain "unacceptably high" according to federal public health officials (Center for Disease Control and Prevention, 2002). The chronic violence in neighborhoods where inner-city youth live has been compared to a war zone by some experts (Bell & Jenkins, 1993). An estimated 20 to 50% of children in the United States are victims of violence within their homes, at school, and in their communities (Finkelhor & Dziuba-Leatherman, 1994). A visitor to a Washington D.C. eighth-grade classroom asked the children, "How many of you know someone who has been killed?" Fourteen of the nineteen children in the class raised their hands. When asked how the killings happened, the children responded, "Shot, stabbed, shot, shot, drugs, shot" (Zinsmeister, 1990).

Several studies have documented the broad range of negative sequella of community violence exposure for children and adolescents. Research has identified several clinically significant disturbances associated with community violence exposure, including: posttraumatic

stress disorder (Fitzpatrick & Boltizar, 1993; Jaycox et al., 2002; Martinez & Richters, 1993; Singer, Anglin, Song, & Lunghofer, 1995; Stein et al., 2001); other anxiety disorders (Osofsky, Wewers, Hann, & Fick, 1993); depression (Martinez & Richters, 1993; Overstreet, 2000); and, dissociation (Putnam, 1997). Community violence has also been associated with impaired cognitive and academic functioning, such as: impairment in school functioning (Saigh, Mroueh, & Bremner, 1997; Schwab-Stone, Kasprow, Voyce, Barone, & Shriver, 1995); and, decreased IQ and reading ability (Delaney-Black et al., 2002). Community violence has also been associated with aggressive behavior (Bell & Jenkins, 1993; Farrell & Bruce, 1997; Garbarino, Dubrow, Kostelny, & Pardo, 1992). Alarmed by the escalating rates of community violence and the pervasive negative consequences it has for children and adolescents, public health officials have identified violence as one of the most significant health issues facing America (Koop & Lundberg, 1992).

Prevalence & Predictors of Youth Exposure to Community Violence

Early Studies on Community Violence

Carl Bell, M.D., was one of the first professionals to address the prevalence and clinical consequences of community violence. Since 1976, when he treated a four-year-old girl who had watched her mother get stabbed, Dr. Bell has worked tirelessly to address the social threat of violence in urban communities (Hicks-Ray, 2004). In 1984, Dr. Bell surveyed 534 children, from the second to eighth grade, in an inner-city setting. He found that one third of them had witnessed a shooting or stabbing. In a 1989 survey, Bell & Jenkins (1991) found that of 1000 schoolchildren, 40 percent had seen a shooting, four percent had been stabbed, 10 percent had been shot, and 23 percent had witnessed a murder (Hicks-Ray, 2004). Another study conducted by Bell & Jenkins (1993) involved 203 teenagers who lived in one of the most crime-ridden areas of Chicago. This study found that 60 percent of the children had seen a shooting, 45 percent had seen a stabbing, and 43 percent had witnessed a murder.

As a result of his pioneering research, Bell made important observations relative to the effects of community violence. He found that

children who had been traumatized once ere more likely to suffer from post-traumatic stress and anxiety, while those who were under chronic stress that continually traumatized them were more prone to behavioral problems and academic underachievement.

Other early studies on the prevalence of community violence yield similarly shocking results. A study by Chicago's Community Health Council found that nearly 40 percent of 1,000 Chicago high school children and elementary students had witnessed a shooting, more than 33 percent had seen a stabbing, and 25 percent had seen a murder (Kotulak, 1990). In the mid eighties, Los Angeles County law enforcement officials estimated that 10-20 percent of the annual 2,000 homicides were witnessed by dependent children (Pynoos & Eth, 1985). In New Orleans, over 70 percent of the children in one study had seen weapons being used, and nearly 40 percent had seen dead bodies (Osofsky et al., 1995). Another study of Chicago middle and high school students found that 35 percent had seen a stabbing, 39 percent had seen a shooting, and 24 percent had seen a killing (Bell & Jenkins, 1993).

These early studies on the prevalence of community violence were conducted over ten years ago. Violence statistics indicate that the levels of

violence experienced by inner-city youth only continues to escalate in prevalence and severity. The next section will summarize the results of these studies which provide additional data related to the types of violence youth are exposed to, as well as demographic data relevant to community violence.

Prevalence Rates of Exposure to Community Violence

Community violence has received increased publicity and the term has been used to describe a broad range of types of violence, therefore a clarification of the definitions and distinctions is appropriate. Community violence is most commonly described as acts by a person or a group of individuals intended to harm another person or group of individuals (e.g., being chased, threatened, beaten up, robbed, mugged, raped, shot, stabbed, or killed; Buka, Stichick, Birdthistle, & Earls, 2001). When reporting exposure rates, researchers often categorize the types of violence that children are exposed to, based upon the impact of the violence on the child. Authors often distinguish between direct (primary) exposure or victimization, and indirect exposure, such as witnessing violence (Osofsky et al., 1993; Richters & Martinez, 1993; Singer et al., 1995). Direct exposure, or victimization, describes exposure in which the violence is targeted at

the child (Buka et al., 2001; Overstreet, 2000), whereas indirect exposure is most commonly described as violence that is directly witnessed by the child (Fitzpatrick & Boldizar, 1993).

Another distinction which has been made in the literature concerns the nature of the community violence under investigation. Some studies have reported on overall rates of violence (Jaycox et al., 2002), others have made distinctions, such as whether the violence involved a weapon (Osofsky et al., 1993), whether the violent act took place during a crime (Bell & Jenkins, 1993; Stein, Jaycox, Kataoka, Rhodes, & Vestal, 2003), or whether the violence was physical in nature (Singer et al., 1995). Several of these categories may overlap, as community violence can easily comprise each of the three elements (e.g., being robbed at gunpoint). Similar overlap can occur regarding types of exposure to violence youth have experienced. For instance, an inner-city youth who has witnessed extreme violence (e.g., a shooting), may have also been the direct victim of another type of violence (e.g., physical assault). The chronic nature of community violence can yield multiple types of exposure to a various forms of violence. Several studies have attempted to make distinctions between the prevalence of these different forms of violence and the levels of exposure.

Inner-city youth are at major risk of being exposed to community violence, with minority youth being at highest risk. Research indicates that the prevalence of urban children and adolescents witnessing violence in their communities has reached epidemic proportions. In one of the first empirical studies examining the prevalence of community violence, Bell and Jenkins (1993) conducted a survey of more than 500 youth attending schools in the south side of Chicago. They found that more than one-fourth of all children interviewed had either witnessed a shooting or murder. The majority of these youth were children of color. Other studies have examined exposure to community violence among relatively high-risk populations, defined as: male, inner-city, African American, and economically disadvantaged adolescents and children. In these studies, as many as 97% of the adolescents and children disclosed being a witness of some form of community violence; and, as many as 70% reported being victimized (Fitzpatrick & Boldizar, 1993; Osofsky et al., 1993; Gelinas, 2001). There clearly appears to be a discrepancy in the severity and frequency of community violence between inner-city neighborhoods and more affluent areas in America. Several studies provide statistical evidence of these socio-economic disparities.

Estimates of reported weapon-related violence vary widely depending upon the chosen sample and study methodology (Stein et al., 2003). Overall, rates of witnessing weapon-related violence are higher than rates of direct victimization. An examination of victimization and weapon-related community violence in a nationally representative population of 4,590 seventh to twelfth graders, 12% reported that someone had pulled a knife or gun on them, 5% indicated that someone had stabbed them, and 1% reported they had been shot (Guterman, Hahm, & Cameron, 2002). Rates of community violence involving weapons are generally higher in studies of high-risk populations. A comparison of youth from urban and suburban Philadelphia neighborhoods found that far more of the urban youth reported having been caught in gun crossfire than the suburban adolescents (24% vs. 4%) (Campbell & Schwartz, 1996). A similar study compared youth from Baltimore's inner city with youth from Maryland middle/upper class community (Gladstein, Rusonis, & Heald, 1992). The study indicated that more inner-city youth reported witnessing a shooting (42% vs. 4%), stabbing (25% vs. 9%), and assaults with a weapon (33% vs. 13%). The inner-city youth were also more likely to report having been shot (3% vs. 1%), and stabbed (5% vs. 2%).

There is also vast difference between different socio-economic areas in regards to the levels of exposure to physical and crime-related community violence. Prevalence rates of slapping, hitting, and punching are relatively high, with rates of child witnessing ranging from 44% to 82% (Richters & Martinez, 1993; Singer et al., 1995). In a study of high school students, more than a third reported having been in a physical fight within the past year, 4% of whom were injured badly enough to warrant medical attention (Center for Disease Control and Prevention, 2002). Younger children are also exposed to physical violence; 78% of 7-15 year old children have reported witnessing a beating (Bell & Jenkins, 1993).

Rates of exposure to crime-related violence vary widely from community to community. Fitzpatrick and Boldizar (1993) found that 43% of their predominantly African-American, low-income children (ages 7-18), reported having witnessed a murder, compared to only 1% of Goldstein's sample of 12-24 year-old middle/upper class youth (Gladstein et al., 1992). In a study of elementary school students in a public housing complex in New Orleans, 6% reported having witnessed a murder and 76% reported having heard about a murder (Osofsky et al., 1993).

Campbell and Schwartz (1996) also found that urban children were more likely than suburban children to report having witnessed a murder (22% vs. 3%) and to have heard about one (52% vs. 17%).

Predictors of Exposure to Community Violence

Several of the community violence studies present findings of selected variables which are considered predictors of exposure to community violence. These predictors may also be considered characteristics or attributes which may range from gender to ethnicity. The most common predictors of exposure to community violence which have been examined include: gender, age, ethnicity/culture, and socioeconomic status. Across studies, gender and age have been the most commonly examined. Most studies have found that males and older children have more community violence exposure. Urban, racial and ethnic minority status, as well as family socioeconomic status, have been commonly examined, and are often associated with community violence exposure. Fewer studies have examined the relationship between community violence and psychological or behavioral problems, exploring whether these problems contribute to higher levels of exposure to violence. Due to the complexity of the phenomenon of community

violence and methodological challenges, there have been some discrepancies in the findings related to predictors of exposure. This section will present a summary of the findings related to the most thoroughly researched predictors of community violence exposure.

With the exception of sexual assault and rape, studies have repeatedly found that boys are at greater risk of exposure to community violence (Fitzpatrick & Boldizar, 1993; Jaycox et al., 2002; Singer et al., 1995; Weist, Acosta, & Youngstrom, 2001). In a large study of students from six public high schools, boys were more likely than girls to report they had witnessed a shooting, been shot at, and been mugged (Singer et al., 1995). The gender differences appear to be greater for direct violence victimization compared to indirect witnessing of violence (Jaycox et al., 2002). Schwab-Stone et al. (1995) also found that boys were exposed more frequently to violence than girls; however, they noted that girls reported feeling unsafe in more situations than boys. This increased sensitivity is also demonstrated diagnostically, with girls experiencing more severe posttraumatic symptoms than boys following exposure to violence (Pynoos, Steinberg, & Goenjian, 1996).

Higher rates of community violence exposure have commonly been found among older youth compared to younger children, but these findings are somewhat inconsistent. Richters and Martinez (1993) survey of elementary school children in Washington, DC, found that older children were more likely to report victimization (32% vs. 19%) and indirect exposure to community violence (72% vs. 61%). High school students were found to have school-associated homicide rates three and a half times higher than students in elementary schools (Anderson et al., 2001). Weist et al., (2001) also found that older children had significantly cumulative violence rates and were more likely to know victims personally.

Several studies, however, have not reported significantly higher rates of community violence exposure in older children compared to younger children (Bell & Jenkins, 1993; Fitzpatrick & Boltizar, 1993; Schwab-Stone et al., 1995). Schwab-Stone et al. (1995) found higher rates of exposure among 8th graders than 6th or 10th graders. Similarly, age was not associated with rates of witnessing a killing, a shooting, or a stabbing in a group of children aged 7-15 years old living in an inner-city Chicago neighborhood (Bell & Jenkins, 1993). Bell and Jenkins (1993) speculated

that many of the children they surveyed had already witnessed high levels of violence at a very young age because violence was so common in their community. This hypothesis is supported by several studies that have documented very high rates of community violence exposure among very young populations (Osofsky, 1995; Dubrow & Garbarino, 1989).

Research studies indicate that there are higher rates of youth community violence exposure in low-income, urban, and predominantly minority communities. For example, the annual rate of school-associated homicides between 1994 and 1999 for African-American students was six points higher than for Caucasian students (44% vs. 38%) (Anderson et al., 2001). Students in urban schools had a school-associated homicide rate twice that of students in suburban schools and four and a half times the rate in rural areas (Andersen et al., 2001). Schwab-Stone et al. (1995) found that African American and Latino students they surveyed were almost twice as likely to report having witnessed a shooting or a stabbing in the past year as Caucasian students in the same urban public school system.

Children's behavioral and psychological problems have also been associated with higher levels of exposure to community violence. Youth exhibiting antisocial behavior such as gang membership, deviant peer

affiliation, delinquencies, and involvement in criminal activity, were more likely to be exposed to community violence (Overstreet, 2000). In a study of inner-city youth in Baltimore, prior arrest history was associated with a higher probability of being a victim of community violence (Weist et al., 2001). In a study of "serious and violent" incarcerated male juvenile delinquents, 76% had been punched or hit, 40% had been threatened with assault, and 31 % had witnessed a murder (Shahinfar, Kupersmidt, & Matza, 2001). The researchers found that adolescents who were inclined to approve of aggressive behaviors were more likely to have been victims of severe violence. "Though there is a clear association between behavioral problems and exposure to violence, the causal direction of that association is most likely bidirectional" (Stein et al., 2003, p. 261). Behavioral problems are both a predictor of exposure to violence and a consequence of exposure (Lynch, 2003)

The Detrimental Effects of Chronic Community Violence

The consequences for children who grow up amidst chronic violence can be devastating. Experience with chronic violence does not inoculate children against negative outcomes; instead, it tends to increase their susceptibility to developmental harm and post-traumatic stress

(Pynoos & Eth, 1985). This section will present an overview of the psychosocial risk factors which have been associated with chronic community violence.

There appears to be a difference between children's reaction to acute single-episodic violence versus chronic community violence. Osofsky et al. (1993) indicated several outcomes which can be expected by children exposed to chronic community violence. The children exhibit difficulty concentrating, because of lack of sleep and intrusive imagery. There is memory impairment because of avoidance or intrusive thoughts. Children exposed to chronic violence had anxious attachment to their mothers. Aggressive play has been observed in these children, including imitating violent behaviors witnessed, as well as demonstrating desperate attempts at self protection. Children living amidst chronic violence also exhibited tough behaviors to hide fears, and uncaring behavior resulting from repeated hurt and loss. There was severe constriction in activities, exploration, and thinking, caused by fears of re-experiencing the traumatic event.

There are several factors which determine how children respond to the challenge of growing up in environments besieged by community

violence. The child's inner resources and their social support system affect the impact which community violence has upon them. The response of caregivers to incidents of violence greatly impacts the child's coping skills and capacity to recover (Pynoos et al., 1987). In contrast, increased parental anxiety can exacerbate negative child reactions to community violence. Most children are able to cope with dangerous environments and maintain reservoirs of resilience as long as parents are not pushed beyond their "stress absorption capacity" (Garbarino et al., 1992).

Age and developmental level are important factors in children's responses to community violence (Garbarino et al., 1992). Preschool children tend to exhibit passive reactions and regressive symptoms as responses to exposure to violence, including: enuresis, decreased verbalization, and clinging behavior. School-age children display increased aggression, somatic complaints, and learning difficulties as a result of experiences with violence. Adolescent responses to community violence are characterized by a "premature entrance into adulthood or a premature closure on identity formation" (Pynoos & Eth, 1985).

Many youth living in violent urban environments are repeatedly confronted with the death and loss of people close to them, including

friends, family, and immediate care-givers. Grief and loss reactions are common among children living in violent neighborhoods. Research indicates that the death of a care-giver in childhood can lead to later psychiatric disorders, especially depression (Rutter, 1990). Young children often have confusing and frightening grief and loss reactions (Osofsky et al., 1993) Grieving may also be complicated and impeded by rage and the desire to punish the perpetrator (Pynoos & Eth, 1985).

Chronic community violence can also impair intellectual functioning and is associated with several school-related problems. Children who have been exposed to life threatening situations or have witnessed injuries to others exhibit serious difficulties related to concentration and performance in school. Pynoos et al. (1987) suggest that these difficulties occurred because the intrusion of thoughts related to violent experiences distracted the children and prevented them from concentrating on schoolwork.

Youth exposed to chronic violence may form a pathological adaptation to violence (Garbarino et al., 1992). High crime rates and levels of violence can impair sound moral judgment and development. When pro-social behavior is not demonstrated and encouraged in the family or

community, truncated moral development is the result (Garbarino et al.). Repeated exposure to violence can also lead to what appears to be a functional adaptation to the violence but which is actually a pathological effort. Participation in dangerous, violent activities loses its threatening character and takes on a special meaning. Violence can gradually become a "normal" part of growing up for inner-city youth and become incorporated into their personality structure. "One way to feel safer is to align yourself with those who frighten you, and children's early adaptation to violence may lead to a process of identification with the aggressor" (Garbarino et al., p. 65). The following section will examine the multitude of factors which contribute to violent behavior in urban youth.

Aggression and Violence among Inner-City Youth

The specific psychosocial risk factors which contribute to violent behavior in inner-city youth are difficult to delineate. Influences range from early attachment, temperament and individual personality characteristics to the broader social systems which may perpetuate inequality and the propensity for violence. Comparison of empirical studies indicates that violent behavior in youth is linked with variables in the following domains: individual, family, school, peer, community, and

culture (Kashani, Jones, Bumby, & Thomas, 1999). This section will summarize the research related to the multiple factors which contribute to youth violence ranging from early attachment patterns to broader societal contributing factors.

Theories of the Development of Violence and Aggression

Several psycho-social theories have proposed conceptual models for the development of violent and aggressive tendencies. Advances in social learning and social-cognitive theories provide plausible hypotheses for how aggression is acquired and develops, what accounts for individual differences in patterns of aggressive behavior, and ways to reduce or prevent violent behaviors. This section will briefly present the theoretical explanations for the development of aggression, as conceptualized by major theoretical models.

The pioneers of social learning theory believe that "people are not born with preformed repertoires of aggressive behavior. They must learn them," (Bandura, 1983, p. 4). Unlike instinct and drive theories that focus on the inner factors that impel aggression, social learning theory focuses on controllable environmental influences, as well as learned cognitive and self-regulatory influences (Pepler & Slaby, 1994). According to social

learning theory, aggressive behavior is acquired and maintained through the following interpersonal processes: (a) observational learning (e.g., modeling of aggressive behavior); (b) direct experience (e.g., rewards or punishment for aggression); and (c) self-regulative influences (e.g., engaging or disengaging one's aggressive behavior from evaluative self-reactions), (Bandura, 1963).

Social-cognitive theories have focused on various ways in which cognitive factors relate to aggression. Cognitive factors contributing to aggression are hypothesized to (a) be acquired through learning and development; (b) contribute to an individual's own proactive exposure to and interpretation of social experiences that foster aggression; (c) mediate an individual's aggressive response to social experiences; (d) account for individual inconsistencies in patterns of aggression, victimization, and bystander support for violence; and (e) be amenable to change in ways that prevent or reduce aggression (Pepler & Slaby, 1994). Several social-cognitive models have evolved in attempts to describe aggression. Among them are: social information-processing models; cognitive script models; the social problem-solving paradigm; the attribution paradigm; and the development of interpersonal understanding paradigm.

The social-interaction model has focused on the primary contexts of social learning during successive phases of development (Patterson, Reid & Dishion, 1992). In the first phase of the social interaction model, maladaptive parent-child interaction patterns and ineffective parental practices are viewed as key determinants of young children's coercive and antisocial behavior patterns. These maladaptive behavior patterns transfer in the second phase to other contexts, such as at school, where children's aggressive patterns may interfere with learning and the development of positive peer relationships. In the third phase of this developmental model, during late adolescence, academic failure and peer rejection lead aggressive children to show increased risk for depression and involvement in deviant peer groups.

The theoretical models presented offer some plausible explanations for the development and maintenance of aggression. In addition, several specific psycho-social variables have been identified which are associated with aggression and violent behavior in youth.

Psychosocial Factors Contributing to Youth Violence

There have been a number of individual characteristics which are associated with violent behavior in youth. A difficult temperament during

infancy has been associated with aggressive behavior during childhood and adolescence. Children, who experience early relational trauma, and subsequent disorganized attachment, have been found to have a predisposition for aggression and violent behaviors in the future (Schore, 2003). The initiation of delinquent and violent behavior early in a child's life puts him or her at a high risk for violent behavior in adolescence and adulthood (Howell, 1995). Another individual characteristic associated with violent tendencies are cognitive capabilities. Cognitive deficits have been found among youth who exhibit violent behavior. Specifically, violent youth possess lower levels of moral reasoning, abstract reasoning, and problem solving (Kashani, et al., 1999).

There have been a variety of familial factors that have been associated with violent behavior among youth. Specific contributory variables include: a family history of criminal behavior and substance abuse, family management problems, family conflict, and parental attitudes favorable toward crime and substance abuse (Howell, 1995). Parents of violent youth often fail to reinforce pro-social behaviors and tend to model aggressive behaviors towards others (Patterson et al., 1992; Widom, 1989). Overly harsh parental discipline and insufficient

monitoring are also associated with aggression in youth (Farrington, 1991; Loeber & Stouthamer-Loeber, 1987). Families of aggressive youth also show low warmth, low cohesion, and high levels of marital conflict (Borduin & Henggeler, 1987; Gorman-Smith, Tolan, Zelli, & Huesmann, 1996; Jouriles, Bourg, & Farris, 1991). Parent-child interaction patterns are also problematic in families of violent youth. Families of aggressive youth often demonstrate a coercive process of interaction that ultimately leads to the development and intensification of aggressive behavior in children (Patterson et al., 1992). One of the most significant psychosocial risk factors associated with youth violence is intra-familial violence. Adolescents who were maltreated as children commit more violence than do adolescents who were not maltreated as children (Kashani & Allan, 1998).

The school environment and children's academic functioning have also been associated with violent tendencies among youth. Strict and inflexible classroom rules, teacher hostility, and lack of classroom management have been linked to aggression in youth (Frude & Gault, 1984). Similarly, youth in overcrowded schools are more aggressive toward peers than adolescents attending uncrowned schools (Stephenson

& Smith, 1989). In the classroom environment, aggressive children have been observed to be more disruptive and off-task than non-aggressive peers (Dodge, Coie, & Brakke, 1982). Poor academic functioning and negative attitudes have also been associated with aggressive youth. Additionally, low academic achievement, academic failure, lack of commitment to school, and school drop-out have been associated with delinquent and aggressive behavior (Hinshaw, 1992).

The influences of peer relationships are another contributing risk factor for violence among youth, especially adolescents. Youth with poor peer relations exhibit verbally and physically aggressive behaviors that ultimately result in their rejection by pro-social peers. Consequently, these youth tend to associate with other rejected peers with maladaptive interpersonal skills (Dodge et al., 1982; Parker & Asher, 1987). Affiliation with deviant peers has been found to be strongly correlated with antisocial behavior in youth (Borduin & Schaeffer, 1998). Aggressive adolescents become less violent when placed in groups with non-aggressive peers, and they revert to aggressive conduct when placed in groups with other aggressive peers (Feldman, Caplinger, & Wodarski, 1983). " Aggressive and other delinquent youth may associate with

antisocial peers as a way of meeting needs unfulfilled by their families of origin or by pro-social peer groups" (Kashani et al., 1999, p. 203). This strong affiliation is apparent in juvenile gang members who have reported that they derive a sense of belonging, purpose, and control over their environment that accompany gang membership (Walker, Schmidt, & Lunghofer, 1997).

Numerous community-related variables have been linked with youth violence. These variables include the availability of firearms, drugs, and alcohol. Youth who carry guns or other weapons commit more violent acts than other youth. Delinquent youth who use street drugs or began using alcohol at an early age have higher rates of aggression and committing violent acts (Kingery, McCoy-Simandle, & Clayton, 1997; Moss & Kirisci, 1995). Neighborhoods characterized by poverty, disorganization, frequent transition, and a low sense of community tend to have high rates of youth violence (Hawkins, 1995). As expected, exposure to violence in the community is positively correlated with the frequency of violent adolescent behavior (Farrell & Bruce, 1997)

The research indicates that there are myriad factors associated with violence among youth. There is also a disproportionate rate of youth

violence among specific ethnic and racial groups found in urban cities. Researchers have proposed several hypotheses for the disproportionately high rates of violence among minority groups in the United States. These socio-cultural differences and possible explanations will be presented in the next section.

Socio-cultural Inequities Contributing to Violence among Minority Youth

The incidence and prevalence of violence differ across social and cultural groups in the United States. In particular, violent crime victimization and perpetration rates have consistently revealed differing patterns of violence associated with each of the dominant ethnic groups in the United States: African-Americans; Latino; Asian-American; and Native American (Hill, Soriano, Chen, & LaFromboise, 1996). Homicide is the number one cause of death among African American youth. For U.S. Latino and Native American youth, research indicates that victimization rates from violent crime are higher than those for Whites (Hill et al., 1996).

Researchers have questioned what the relationship is between racial and ethnic differences in the United States and varying rates of violence. Correlations have been found between risk factors for violence and population demographics. Data indicate that social risk factors such

as unemployment, high population density, poverty, and drug abuse, among others, are associated with being both victims and perpetrators of violent crimes (Hill et al., 1996). Population demographics indicate that these risk factors are over represented among members of ethnic minority groups and may in part account for the disproportionate rates of violence among ethnic minority groups. Other researchers suggest a more complex relationship between violence and minorities. Violence may be the result of a number of historical, economic, social and psychological forces that are associated with the lives of ethnic minority members. "Several studies support the hypothesis that it is the combination of poverty and other variables reflecting structural inequality, racism, and discrimination that place some groups at higher risk than others" (Hill et al., 1996, p.60).

There are numerous socio-cultural factors which may place urban minority youth at higher risk of exposure to violence in their communities. Hill et al. (1996) describes how institutionalism racism is experienced by youth from their experiences in the educational system to limited employment opportunities.

> In these institutional settings, youth may have to deny large parts of themselves in order to survive, may internalize negative images of their group from the dominant society, and may fail to adopt an ethnic cultural identity. Each of these factors has been thought to

make youth highly vulnerable for socialization towards violence (p. 69)

Socio-economic factors, which have been identified as highly correlated with violence among urban minority youth, include poverty and inequality. Poverty, not race or ethnicity, has been found to be the greatest predictor of violence (Hill et al., 1996). However, there appears to be a complicated relationship between poverty, violence, and race. Poverty alone is not primarily correlated with violence. "Rather, it is the absence of sufficient income to meet basic necessities in a given geographical context, compounded by inequality and lack of or limited access to needed resources because of discrimination and institutional racism, that may account for the increased violence among ethnic minority groups" (Hill et al., 1996, p.69).

Several researchers have argued that the expression of violence among disadvantaged minority youth is directly tied to their inability to navigate the status mobility system in the United States (Hill et al., 1996). Wilson (1990) argues that violence among African American, and other minority youth, is tied to vain attempts to achieve basic, positive human ends in an environment that does not support those efforts, which results in attempts to achieve them by negative means:

> It represents an often misguided furious struggle for self-affirmation by many African-Americans while entangled in a White American-spun spider's web specifically designed and constructed to accomplish their disaffirmation…For too many African American youth, being cut off from the paths to legitimate and self-determined personal accomplishment as a result of the underdeveloped power of the African American community, the violent subduing of others may often be their only significant achievement and 'claim to fame.' Their capacity to perpetuate violence is the great equalizer in a world characterized by great inequalities. (p. xvii)

Violence appears to be inextricably woven into the "normal" development of many inner-city youth. Research suggests that inner-city violence involves is a vicious cycle whereby, young victims often later become perpetrators of violence. There does not appear to be one single factor which predisposes youth to have violent tendencies; however, exposure to violence has been indicated as one of the strongest predictors of future violence and aggression (Singer et al., 1995). Even for those minority youth who do not succumb to perpetrating violence, they have a disproportionately higher chance of becoming victims of violence than their White counterparts. For those rare youth who escape directly experiencing violence in their lives, there remains the likelihood that they will witness violence in their homes or communities. An increasing amount of research suggests that childhood exposure to community

violence can produce symptoms of psychological disturbance and that there may be a cumulative effect of traumatic stressors caused by the environment. An increasing amount of research suggests that childhood exposure to community violence can produce PTSD and other symptoms of psychological disturbance. There is also evidence that there may be a cumulative effect of traumatic stressors caused by the environment. The following section will present current research related to trauma, its affect upon youth, and the association between community violence, traumatic stress responses and other psychological disturbances.

Trauma

Trauma profoundly affects both the mind and body of its victims. It is a disorder which can alter the natural physiological processes of the human organism. Recent research has been able to identify some of the neurological processes damaged by trauma and the resulting alterations to normal biological functions. This paper will begin by presenting the definition of trauma and the DSM-IV diagnosis of Posttraumatic Stress Disorder. Research indicates that there are numerous variables related to trauma and symptom manifestations which expand beyond the scope of the DSM-IV. The type and duration of trauma also impact the symptom profile. Therefore, the characteristics of other traumatic syndromes will be examined. Then the neurological and biological processes affected by trauma will be examined. The affect trauma has upon specific domains will be discussed such as: memory, affect regulation, integration of experience, and interpersonal relationships.

Trauma Defined

Trauma is a term used to describe a very broad range of overwhelming experiences which can have diverse effects upon people.

Overwhelming and painful experiences are part of human nature and often can facilitate growth, resilience, and mature development.

> Despite the human capacity to survive and adapt, traumatic experiences can alter people's psychological, biological, and social equilibrium to such a degree that the memory of one particular event comes to taint all other experiences, spoiling appreciation of the present" (van der Kolk, 1996, p. 4)

One of the most problematic aspects of trauma is its seemingly encapsulated and timeless persistence which prevents it from being integrated with other life experience. This section will attempt to capture the salient characteristics of events which are experienced as traumatic. In addition, the myriad of symptoms and psychological disorders which are associated with trauma will be examined.

The DSM-IV-TR (American Psychiatric Association, 2000) describes the specific qualities of a traumatic event which must precipitate a diagnosis of PTSD. The person must have been exposed to a traumatic event in which both of the following were present: a) the person experienced, witnessed, or was confronted by an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; b) the person's response involved intense fear,

helplessness, or horror (or in children, the response must involve disorganized or agitated behavior; APA, 2000, p. 219).

The symptoms of PTSD as identified by the DSM-IV can be divided into three broad categories: (a) the repeated reliving of memories of the traumatic experience; (b) avoidance of reminders of the trauma, and the numbing, detachment, and emotional blunting that often coexist with intrusive recollections; and, (c) a pattern of increased arousal (van der Kolk, 2003).

Re-experiencing may include intrusive recollections of the traumatic event, distressing dreams, and the sense of reliving the event. Traumatized individuals also experience intense psychological distress at exposure to internal or external cues that symbolize the traumatic event. Avoidance and numbing responses involve efforts to avoid thoughts, feelings, or conversations associated with the trauma; as well as, activities, places or people that arouse recollections of the event(s). Individuals may also experience an inability to recall an important aspect of the trauma. Numbing responses may include: diminished interest in significant activities, feeling estranged from others, restricted range of affect, and a sense of foreshortened future. Persistent symptoms of increased arousal

include at least two of the following: difficulty sleeping, irritability or anger, difficulty concentrating, hypervigilance, and exaggerated startle response (APA, 2000, p. 219-220).

There have been several criticisms related to the limitations of the DSM-IV categorization of Posttraumatic Stress Disorder. One criticism has been that there appear to be qualitatively different traumatic response syndromes (Terr, 1990; Herman, 1992; van der Kolk, 1996). Another criticism is that the PTSD diagnosis focuses upon the phenomenological qualities of trauma, and neglects many of the physiological aspects unique to trauma (van der Kolk, 2003). There tends to be excessive emphasis upon the PTSD symptoms of intrusion, numbing, and arousal at the expense of characterizing other personality changes. More recently there has been recognition of the profound personality changes that can follow childhood trauma or prolonged exposure in adolescents and adults (van der Kolk, 1996). The following section will address recent research related to the physiological systems which appear to be affected by traumatic experiences and the related responses which lead to symptom manifestation.

Variations of Traumatic Response and Related Syndromes

Trauma experts have delineated a traumatic syndrome of psychological problems which have been shown to be frequently associated with histories of prolonged and severe trauma or abuse. This syndrome has been characterized as Complex PTSD (Herman, 1992) or Disorders of Extreme Stress Not Otherwise Specified (DENOS) (van der Kolk, 1996). Diagnostically, individuals with complex traumatic syndrome present the following history of prolonged abuse and/or exposure to violence.

Characteristics of this complex traumatic syndrome include: alterations in affect regulation, self-perception, and relations with others (Herman, 1992, p. 121). This complex trauma syndrome, appears to be more deeply ingrained in the personality structure of the individual than the symptoms of PTSD caused by a single traumatic event. Individuals suffering from complex PTSD often experience tumultuous interpersonal relationships, similar to the relational patterns experienced by individuals with borderline personality disorder. “The chronically abused person’s apparent helplessness and passivity, her entrapment in the past, her

intractable depression and somatic complaints, and her smoldering anger often frustrate the people closest to her" (Herman, 1992, p. 115).

During the DSM-IV field studies to define a more comprehensive definition of PTSD, the committee distilled various core symptoms out of as a tentative criteria for "disorders of extreme stress not otherwise specified" (DESNOS), and clustered these symptoms into five categories (van der Kolk, 1996). Eventually, these symptoms were incorporated into the DSM-IV under the "Associated Features and Disorders" section of the PTSD diagnosis (APA, 1994). However, the inclusion of these symptoms under the general diagnosis of PTSD neglected to delineate DESNOS or complex trauma as a distinct disorder. Table 1 presents the originally proposed criteria for Disorders of Extreme Stress Not Otherwise Specified proposed by van der Kolk (1996, p. 203).

Table 1: Disorders of Extreme Stress Not Otherwise Specified

(DESNOS) Proposed Criteria

A. Alterations in regulating affective arousal

(1) chronic affect dysregulation

(2) difficulty modulating anger

(3) self-destructive and suicidal behavior

(4) difficulty modulating sexual involvement

(5) impulsive and risk-taking behaviors

B. Alterations in attention and concentration

(1) amnesia

(2) dissociation

C. Somatization

D. Chronic chacterological changes

(1) alterations in self-perception: chronic guilt and shame; feelings of self-blame, of ineffectiveness, and of being permanently damaged

(2) alterations in perception of perpetrator: adopting distorted beliefs and idealizing the perpetrator

(3) alterations in perceptions of others:

(a) an inability to trust or maintain relationships with others

(b) tendency to be re-victimized

(c) a tendency to victimize others

E. Alterations in systems of meaning

(1) despair and hopelessness

(2) loss of previously self-sustaining beliefs

The reactions to trauma appear as variable as the different types of trauma that can happen to a person. Additionally, research suggests that there is a strong subjective component to how each individual responds to any given trauma. Therefore, even the same objectively similar traumatic events often result in different posttraumatic reactions. Experts argue that there are qualitative differences between specific types of posttraumatic reactions. However, there do seem to be some common psycho-physiological reactions that occur during overwhelming events. The next section will address the physiological processes which occur when the human body experiences trauma.

The Psychobiology of Trauma

The Biology of Trauma

Recent research has led to better understanding of the biological bases of trauma and how these correlate with psychological and physiological responses. Modern research suggests that PTSD is a "physioneurosis," a mental disorder based on the persistence of biological emergency responses (van der Kolk, 2003, p. 177). Chronic trauma-related disorders are qualitatively different from a simple exaggeration of the body's normal stress response system. Trauma, which overwhelms the human organism, seems to affect people over a range of biological functioning, involving a large variety of brain structures and neurotransmitter systems (van der Kolk, 2003).

Trauma appears to affect the functioning of certain areas of the brain. The brain stem, hypothalamus, limbic system and the neocortex monitor external stimuli from the environment and assess what is new, dangerous, or gratifying (van der Kolk, 2003). These interconnected systems of the brain allow the human organism to learn from experience and to entertain a range of alternative responses without becoming disorganized, or impulsively acting upon them. The human brain also

possesses the capacity to form complex mental images and collaborative social relationships that allow complex thought in the context of human relationships. Thus, the quality of social relationships is influenced by the capacity of the brain to discriminately analyze external stimuli and respond in a complex, adaptive manner. People with PTSD often have serious problems carrying out a host of these complex, interrelated functions (van der Kolk, 2003).

The brain systems related to the storing and retrieval of memories also appears to be impacted by trauma. Traumatic memories have unique qualities which separate them from ordinary memories. Van der Kolk (2003) summarizes the research related to traumatic memories as follows:

> traumatic memories are primarily imprinted in sensory and emotional modes;
>
> these sensory experiences often remain stable over time and unaltered by other life experiences;
>
> traumatic memories may return, triggered by reminders, at any time during a person's life, with vividness as if the subject is having the experience all over again;
>
> these sensory imprints tend to occur in a mental state in which victims may be unable to precisely articulate what they are feeling and thinking (p. 179).

Traumatic memories have a unique capacity to remain unchanging over time in relation to their intensity, vividness, and emotional impact. "Triggered by a reminder, the past can be relived with an immediate sensory and emotional intensity that makes victims feel as if the event were occurring all over again" (van der Kolk, 2003, p. 180). Consequently, sensory elements of the trauma may intrude as flashbacks and nightmares. Traumatic memories also lead to altered states of consciousness in which the trauma is relived, unintegrated with the overall sense of self.

Loss of Stimulus Discrimination

PTSD significantly impacts the human organism's capacity to regulate response to stimuli. PTSD results in difficulty regulating responses to two very different types of stimuli: (a) response to specific reminders of the trauma; (b) in response to intense, but neutral stimuli. People with PTSD experience increased autonomic responses to reminders of traumatic experience (van der Kolk, 2003). PTSD also involves hyperarousal to intense, but neutral stimuli. Excessive stimulation of the Central Nervous System at the time of trauma may result in permanent

neural changes. PTSD sufferers typically exhibit an abnormal startle response to neutral stimuli such as loud noises. Traumatic memories are triggered and re-experienced as a result of sensory stimuli which may remind the individual of the traumatic event (e.g., smells, visual images). In addition, individuals with PTSD exhibit hyperarousal to neutral stimuli. Research indicates that trauma suffers exhibit an abnormal acoustic startle response. Failure of the acoustic startle response (ASR) to habituate suggests that traumatized people have difficulty evaluating sensory stimuli and mobilizing appropriate levels of physiological response (van der Kolk, 1996).

Self-Regulation & Integration Difficulties

PTSD results in the failure of the central nervous system to synthesize the sensations related to the traumatic memory into an integrated semantic memory. The areas most related to emotional arousal are activated: the amygdala, the insula, and the medial temporal lobe (van der Kolk, 2003). The information evaluated by the amygdala is passed on to areas of the brain stem that control autonomic and neurohormonal response systems. The amygdala is related to the instinctual flight or flight response in organisms and produces responses in the sympathetic

nervous system. Therefore, the amygdala transforms sensory stimuli into emotional and hormonal signals, thereby initiating and controlling emotional responses (Rosenzweig, Breedlove, Leiman, 2002). Research has shown that the amygdala in people with PTSD is more easily triggered and therefore results in more frequent and indiscriminate responses of the sympathetic nervous systems' fight or flight responses. This may explain the symptoms of hyperarousal and re-experiencing often exhibited by people who have experienced trauma.

Trauma also affects the integrating capacity of the hippocampus. The hippocampus plays an essential role in learning and the integration of experience. The high level of stimulation of the amygdala may interfere with the integrative functions of the hippocampus. Consequently, memories are imprinted as isolated images and sensations separate from other life experiences. This decreased hippocampal functioning caused by trauma can lead to a fragmentation of experience. This may explain why traumatized individuals only remember fragmented elements of traumatic experiences, and why re-experiencing phenomena cause sufferers to feel as if they are reliving the traumatic incident (van der Kolk, 2003).

Neurological research has found that there is a difference between how the left and right hemispheres of the brain process traumatic memories. The right hemisphere is involved in the expression and comprehension of non-verbal communication and allows for integration across sensory modalities. This hemisphere is particularly integrated with the amygdala, which assigns emotional significance to stimuli and regulates hormonal responses. The right hemisphere is very sensitive to emotional nuances; however, it has only a rudimentary capacity to think or communicate analytically, employ syntax, or to reason. In contrast, the left hemisphere tends to be far less active in PTSD. The left hemisphere mediates verbal communication and organizes problem-solving tasks. This limited functioning of the left hemisphere may also explain why trauma victims have such difficulty verbalizing their emotional states related to the trauma. The failure of left hemispheric functioning during states of extreme arousal may be the cause of the derealization and depersonalization reported by PTSD sufferers (van der Kolk, 1996, 2003).

Difficulty processing information and experience between the left and right hemispheres of the brain also prevent the development of coherent and integrated narratives. During the course of development

neural integration across hemispheres is achieved, and the capacity to develop coherent narratives is achieved. Early trauma may induce separation of the hemispheres, impairing the capacity to achieve complex, adaptive, and self-regulatory states as a result of coherent narratives of experience (Siegel, 2003). Assisting individuals to develop coherent narratives about their traumatic experiences can lead to an integration of the experiences, rather than the fragmentation typical of traumatic memories.

Attachment Theory & Interpersonal Aspects of Trauma

Recent research on attachment indicates that early relationships with caregivers can impact both the severity of traumatic reactions as well as the course of development, resiliency and recovery from trauma. Early, prolonged traumatic experiences can have detrimental effects upon the physiological and psychological development of the child. Neglect and emotional deprivation in the first years of life lead to left hipocampal shrinkage, corpus callosum damage, and dendric burnout (Schore, 2003; Siegel, 2003). Trauma during infancy occurs in a critical period of growth of the emotion-regulating limbic system, and consequently affects the maturation of the brain systems that modulate stress and negative affect.

Infants who experience abuse and/or neglect, and who have little interactive repair from an adult or caregiver, are at high risk for developing aggression dysregulation in later stages of life (Schore, 2003).

The misattauned dyadic interactions between the caregiver and child which are characteristics of disorders of attachment can cause severe, long lasting damage. Disorganized attachment may predispose individuals to the development of psychopathology and vulnerability to trauma. The characteristics of early affect-regulating relationships also influence future interpersonal relationships (Fosha, 2003).

Healthy attachment between caregiver and child can foster resiliency against traumatic experiences and reduce the severity of traumatic stress reactions (Fosha, 2003). As Fosha (2003) argues:

> There is evidence that just *one* relationship with a caregiver (and that caregiver does *not* have to be the principal caregiver) who is capable of autobiographical reflection, in other words, a caregiver who possesses a high reflective self function, can enhance the resilience of an individual (p. 223)

These findings lead to critical implications for the clinical treatment of trauma. The therapeutic relationship can potentially become the healing relationship through which the client may develop resiliency and learn to reduce the severity of traumatic stress reactions. In other words, the

therapeutic relationship may provide the adult version of secure attachment.

Traumatic Reactions of Children & Adolescents

Early Studies on Childhood Trauma

One of the first in-depth studies of childhood trauma was Lenore Terr's comprehensive interviews with the children involved in the 1976 Chowchilla kidnapping (Terr, 1979, 1990). In the summer of 1976, 26 children from Chowchilla, California, were kidnapped while riding their school bus. They were driven for11 hours in darkened vans, and then buried alive in an underground truck-trailer. The children, ages 5 through 14 years, dug themselves out after a 16-hour entombment. Terr's (1990) clinical interviews, and her four-year follow-up study, revealed significant differences between childhood and adult PTSD. Although many symptoms exhibited by the Chowchilla children resembled those exhibited by traumatized adults, there were several characteristics unique to childhood PTSD. Several of Terr's findings related to children's unique responses to trauma have been replicated in other clinical studies (Terr, 1979, 1990; Pynoos & Eth, 1985; DiNicola, 1996).

One characteristic of childhood PTSD that Terr (1990) found was children's tendency to re-experience the traumatic event through stereotyped, repetitive posttraumatic play. Terr (1990) coined the term "posttraumatic play" after observing the types of play which the Chochilla children engaged in. Their play tended to be repetitive fantasy reenactments of the actual trauma and did not diminish the children's anxiety about the abduction (e.g. victims playing kidnapping games). Posttraumatic play is characterized by thematically remaining consistent with the trauma, and the child casting him/herself in the role they had during the traumatic event. "After experiencing a trauma a child becomes stuck having to play himself in his play…[and] cannot move away from the trauma far enough to afford himself the relief he expects from play" (Terr, 1990, p. 240). DSM-IV recognizes this type of play by children with PTSD: "In young children, repetitive play may occur in which themes or aspects of the trauma are expressed" (APA, 2000, p. 219).

Children also do not re-experience their trauma through flashbacks, which is one of the significant symptoms of adult PTSD. Children tend to re-experience trauma through vivid daydreaming rather than by unexpected flashbacks (Terr 1990). Similar to the characteristics of adult

PTSD, the Chowchilla children expressed a sense of foreshortened future characterized by diminished expectations of having a normal life-span, marriage, children, or a career (McNally, 1991; Terr, 1990). PTSD in children can also result in developmental disturbances. Many of the Chowchilla children engaged in regressive behavior marked by the loss of previously acquired developmental skills (Terr, 1990).

Terr (1990) found that children previously unexposed to trauma tend not to depend upon denial as a defense mechanism. Rather, denial develops as a defense against repeated trauma. "This childhood tendency not to deny the reality of a trauma makes a striking contrast to the denial one sometimes sees in an adult. The adult may be unable to accept or to remember parts of an incident to which a child responds with vivid, detailed remembrance" (Terr, 1990, p. 78). Children tend to use denial once disasters start piling up. Repeated or long-standing disasters encourage denial and numbing, and the worst kinds will create psychically deadened children (Terr, 1990, p. 79). As a result of these clinical findings, Terr (1990) proposed to two distinct types of childhood PTSD. Type I PTSD results from a sudden, single-impact traumatic event.

Type II results from a series of traumatic events or from exposure to a prolonged traumatic stressor.

Though psychogenetic amnesia was absent, other cognitive disturbances, such as time skew and omen formation, were evident (Terr, 1990; McNally, 1991). Time skew involves the missequencing of events in recall, and omen formation denotes the retrospective identification of harbingers of the traumatic event (McNally, 1991). Nineteen of the twenty-six Chowchilla children reordered or reemphasized time sequences, thus inventing "omens" (Terr, 1990, p. 160). Terr (1990) suggests that this prevalence of omen formation accomplished the psychological goal of providing the children with an answer to the question "Why me?"

Terr's landmark investigation prompted additional research on the effects of trauma on children, and resulted in the inclusion of age-specific features in the DSM-III-R description of PTSD. Terr's findings, however, were based on in-depth, but unstructured, interviews. Subsequent empirical research on childhood PTSD has been based on structured interviews with traumatized children and their parents, questionnaires, and psychophysiological evaluation (McNally, 1991).

Exposure to Violence and PTSD

Pynoos et al. (1987) conducted one of the first empirical studies on the correlation between witnessing violence and the severity of PTSD symptoms children develop over time. His research is particularly relevant to the investigation of community violence and childhood PTSD.

In 1987, there was a lethal sniper attack on an elementary school playground in Los Angeles, California. The sniper shot repeated rounds of high-powered ammunition at children on the playground. One child and a passerby were killed, and 13 other children were injured. Some children on the playground ran screaming, while others dropped to the ground motionless. Groups of children were trapped in their classrooms while the shooting took place. One quarter of the school's students were on vacation during the incident and were not exposed to the event except for media reports. Therefore, there was a broad range of exposure levels experienced by the students in the school: from direct exposure on the playground, to indirect exposure via the media and classmate recollections.

Pynoos and his colleagues conducted structured interviews and administered random assessments to the children in the school (Pynoos et al., 1987). This was the first major study comparable to adult studies on

PTSD in its empirical structure and ability to investigate systematically a large number of children exposed to the same isolated, traumatic event. This study also provided research relative to the effects witnessing violence has upon children, and their subsequent vulnerability for developing PTSD symptoms.

Pynoos et al. (1987) found that, not surprisingly, the shooting had disrupted the entire community, but the prevalence and severity of PTSD symptoms varied among the students. Children showed significant differences in severity proportions across the four exposure levels. As exposure increased, so did the number of stress symptoms reported by the children. Age, sex, and ethnicity did not influence either the type or severity of symptom picture. Degree of exposure to the trauma, as with adults, was the most powerful factor (Gelinas, 2001).

Besides degree of exposure to the trauma, interpersonal attachment was the only other variable which influenced how traumatic the shooting was. Within each level of trauma exposure, the children who knew the girl who was killed had significantly more severe symptoms (Pynoos et al., 1987; Gelinas, 2001). The positive correlation of PTSD symptoms with level of acquaintance to the child killed explained the presence of a severe

or moderate post-traumatic stress reaction in some children who had been in the low exposure groups (Pynoos et al.).

The children with severe to moderate PTSD complained of a cluster of symptoms. These symptoms included intrusive thoughts about the shooting, re-experiencing the event, avoidance of reminders, reduced involvement with the external world, and estrangement from people (Pynoos et al., 1987). These symptoms are similar to the bi-phasic numbing/constriction and intrusive re-experiencing found in adults with PTSD. Similar to Terr's (1979) observation of the Chowchilla children, Pynoos did not find that the children experienced numbing per se. Rather, they described symptoms suggestive of numbing, including lessened interest in play, feeling distant from parents and friends, feeling alone with their emotions, and avoiding their feelings (Gelinas, 2001). Symptoms of increased fear and anxiety were found across severity levels. Disturbed sleep, bad dreams, thoughts of the event interfering with learning, and difficulty paying attention at school were most prevalent.

A follow-up study conducted one year later found that while there was some decrease in PTSD symptoms in all groups of children, 74% of the children who were most exposed to the violence and who witnessed a

death continued to have significantly more persistent PTSD symptoms than the other groups of children (Gelinas, 2001).

Based upon this study Pynoos and his colleagues (1987) made several conclusions about the relationship between witnessing violence and the prevalence and patterns of PTSD symptoms. They concluded that there was a significant positive correlation between the degree of violence exposure and the severity of the posttraumatic stress reaction. The symptom profile among the most severely distressed children was similar to that found in adults. Their study also found that there is a pattern of symptom accrual which suggests that specific symptoms accumulate in response to additional exposure (Mabanglo, 2002, p. 239).

These early longitudinal studies were crucial towards acknowledging the detrimental long-term psychological effects of trauma on children. Prior to such studies, many researchers were unaware of the psychological damage trauma caused children because PTSD symptoms among children were more subtle than those exhibited by adults. Whereas adults could verbalize their traumatic experiences, children expressed their distress through repetitive play. Terr (1990) described how the entire Chowchilla community (including the treating psychiatrist) initially

denied that any of the children exhibited any “problems” after their kidnapping. These studies uncovered the internal traumatic symptoms which many children experience following trauma, but which they are incapable of explaining to adults, or even fully understanding themselves. The following section will describe the general diagnostic criteria of PTSD in children and adolescents, and the developmental differences in symptomotology. Later sections will address the prevalence of violence in minority communities and subsequent vulnerabilities.

PTSD in Children and Adolescents: Diagnosis and Clinical Presentation

Accurate diagnosis of posttraumatic stress disorder in children and adolescents can be complicated by a variety of factors. Stressors which produce PTSD symptoms vary, and recent research indicates that children may be vulnerable to a broad range of direct and indirect traumatizing experiences (Pynoos et al., 1996; Osofsky, 1995; DiNicola, 1996). Duration and type of trauma appear to significantly affect the PTSD symptom profile. Trauma can significantly effect childhood development and impair the capacity to form secure early attachments (DiNicola, 1996). Diagnostically, the age and developmental stage of the child influences the manner in which symptoms are expressed. Children may also develop

PTSD from less dramatic traumatic events, which may remain unrecognized by adults, such as neglect or chronic community violence.

Numerous stressors have been identified which result in PTSD in children and adolescents. Pynoos et al. (1996) indicates that children are especially vulnerable to vicariously experienced traumatic events, as well as directly experienced events. Directly experienced events, which may result in PTSD in children and adolescents, include violent personal assault as well as exposure to violence. Vehicular accidents, severe accidental injuries (e.g. burns), and life-threatening diseases can also cause posttraumatic reactions. Extreme situations such as major disasters, kidnapping, and incarceration in concentration camps can also lead to PTSD.

The vicariously experienced events resulting in PTSD among children and adolescents are further categorized into those events which are personally witnessed and traumatic events experienced (or conveyed) by significant others. Personally witnessed events leading to PTSD include witnessing serious injury or unnatural death of another person as a result of a violent assault. Other traumatic witnessed events include unexpectedly observing a dead body, or witnessing self-injury and

suicidal behavior in others. Events experienced by significant others may include violent personal assault, and serious accident or injury. Learning about the sudden, unexpected death of a family member or close friend, or that a significant person has a life-threatening disease has also been found to produce posttraumatic symptoms in children and adolescents.

In the distinction of diagnostic features of PTSD in DSM-IV, traumatic events are conceptualized as either directly or vicariously experienced. An important distinction is made between vicariously experienced events that are witnessed personally and events experienced by significant others who convey traumatic experiences. DSM-IV emphasizes that the risk of PTSD may increase as the intensity of physical proximity to the stressor increase (APA, 1994). Research also indicates that the severity and longevity of PTSD symptoms tends to increase with proximity (Pynoos et al., 1987). Due to the dependence of children and adolescents on their families, the risk may increase correspondingly as the traumatic events involve closer attachment figures (DiNicola, 1996).

Based upon her extensive clinical work with children, Terr (1990) proposed two forms of PTSD, based upon different types of traumatic experiences. Type I results from a sudden, unexpected single-impact

traumatic event. In this type of PTSD experienced by children, re-experiencing phenomena are typical. Type II results from a series of traumatic events or from exposure to a prolonged traumatic stressor. Characteristics of this type of PTSD are: denial, dissociation, and numbing. Chronic physical or sexual abuse would be an example of traumatic stressors which would produce Type II PTSD. Adaptations to a Type II stressor (e.g., chronic sexual abuse) may produce symptoms associated with borderline and multiple personality disorders. Type II stressors likely produce a diversity of psychiatric disturbances rather than a coherent syndrome with blurred boundaries between Type II PTSD and personality disorders (McNally, 1991). Research appears to indicate that extent of exposure determines risk for the development of PTSD, and that chronic trauma heralds a more profound level of dysfunction with longer lasting impacts (Pynoos et al., 1996; DiNicola, 1996)

PTSD Symptoms and Developmental Variations

The expression of posttraumatic stress symptoms varies depending upon the age and developmental stage of the child or adolescent. Table I indicates the symptom criteria of PTSD in children and adolescents. The

four main diagnostic categories of PTSD include: the direct or vicarious experience of a trauma; re-experiencing phenomena; psychological numbness; and increased state of arousal. These symptom clusters tend to be consistent across age variations; however, the expression and manifestation of symptoms appear to have developmental variations. Currently, the DSM-IV includes the following specifications relative to PTSD in children:

> In children, response to the traumatic event may be agitation or disorganized behavior. Young children may relive the event through repetitive play, trauma-specific re-enactment, or nightmares without recognizable content" (Morrison, 1996, p. 270).

Clinical descriptions of symptoms differentiate age-related developmental responses with each age group processing particular vulnerabilities (Terr, 1990; Pynoos et al., 1996; DiNicola, 1996). Pre-verbal children aged 36 months or younger are unable to put trauma into words. Consequently, they have more persistent perceptual memories evident in play activity or expressed through fears. Preschool age children respond to trauma with decreased verbalization, cognitive confusion, increased anxious attachment, and other regressive symptomotology. School-age children often respond to trauma with aggressive or inhibited behavior

which may become reckless. These children have increased psychosomatic complaints and may obsessively retell the event (DiNicola, 1996).

Adolescents tend to have symptoms which resemble adult responses more than younger children. Adolescents do not engage in posttraumatic play, but rather, they exhibit more sleeplessness, inattentiveness, and irritability. Teenagers with PTSD often express premature independence or increased dependence. Acting out behaviors among adolescents includes: truancy, precocious sexual activity, substance abuse, delinquency, and self-endangering reenactment behavior. Adolescents are also vulnerable to narcissistic rage and taking revenge (DiNicola, 1996).

Long-Term Effects of Childhood Trauma

Early childhood trauma can also produce long-term effects which impact personality structure and increase vulnerability for related disorders (van der Kolk, 1996). Van der Kolk (1996) found early childhood trauma could lead to generalized hypersrousal and difficulty modulating affect. This generalized hyperarousal often results in the following: aggression against self and others; inability to modulate sexual impulses; and problems with social attachments (e.g., excessive dependence or

isolation). The long term effects of early trauma lead to alterations in neurobiological processes involved in stimulus discrimination. Symptoms associated with these alterations are problems with attention and concentration, dissociation, and somatization. There also is a conditioned fear response to trauma-related stimuli. Van der Kolk also found that there was a shattered sense of meaning for these individuals, including loss of trust, hope, and a sense of agency. Social avoidance is another common result of early trauma, resulting in the loss of meaningful attachments and participation in preparing for the future (van der Kolk, 1996, p. 184).

Traumatized children experience difficulty regulating affect and impulse control. Van der Kolk (1996) suggests that self-destructive behaviors may function as attempts at self-regulation. Such self-destructive behaviors often exhibited by adolescents include: self-mutilation, eating disorders, and substance abuse. Dissociation has been found to be a common symptom of PTSD among children who have experienced repeated trauma (van der Kolk, 1996; Herman, 1992). Early trauma can also cause characterological disturbances such as:

internalization of the trauma; impairment of basic trust; and negative effects upon identity and interpersonal relationships (van der Kolk, 1996).

Children and adolescents who have been traumatized are also vulnerable to the compulsion to repeat the trauma. This compulsion may take the form of being revictimized and/or victimizing others (van der Kolk, 1996). This compulsion is particularly relevant to the relationship between PTSD and community violence among urban youth. Childhood victims of violence may later become perpetrators, thus perpetuating a viscous cycle of violence within the urban youth culture. The following section will address the prevalence of violence among urban minority youth and propose reasons for its perpetuation.

Chronic Community Violence and PTSD

In the past, trauma research in children often focused upon direct victimization caused by a single traumatic event. There has been some disagreement regarding the necessity of a traumatic experience to be "outside the range of usual human experience" in order for it to produce stress reactions characteristic of PTSD (Berton & Stabb, 1996). Victimization statistics challenge the assertion that traumatic events - such as assaults and/or shootings - are unusual experiences for inner-city

African American youth. When youth have over a 90% likelihood of witnessing community violence, and 70% chance of being victimized, violence becomes more of an everyday stressor than an isolated traumatic incident (Fitzpatrick & Boldizar, 1993). Compared with major life events, daily stressors have been reported to play a more central role in the development and maintenance of psychological problems (Berton & Stabb, 1996). Researchers have found that as the number of stressors increases, adolescent functioning decreases. "The prevalence and severity of chronic and everyday stressors in the lives of urban adolescents may predispose them to symptoms of psychological stress and PTSD" (Berton & Stabb, 1996, p. 490).

Many inner city youth live in environments in which there is chronic community violence, and ethnic minority youth appear to experience disproportionately higher exposure to such violence. Recent research has indicated that living in an environment where there is chronic community violence is traumatic, and that repeated exposure to violence may have a cumulative psychological impact (Osofsky, 1995; Rosenthal, 2000; Herman, 1992). Fitzpatrick and Boldizar (1993) studied a sample of 221 youth between the ages of 7 and 18 years who were living

in a low-income housing development. They found that 27% of their sample met the criteria for PTSD. Berton and Stabb (1996) found similar results in a study of urban adolescents with 29% indicating clinical levels of PTSD. Clinicians should be concerned when random samples of inner-city youth indicate that over one-fourth meet clinical criteria for PTSD.

Research has indicated a positive correlation between the degree of exposure to community violence and levels of psychological distress (Rosenthal, 2000). Rosenthal (2000) conducted a study which investigated the psychological affects of recurring community violence. This “street” violence was ongoing, as opposed to an isolated traumatic incident. The type of “street” violence studied was specific to recurrent community violence, and ruled out other forms of violence often associated with PTSD. The study focused upon the psychological effects of chronic community violence over a three-year period, rather than the impact of a single traumatic experience. It was defined as public violence as opposed to violence occurring in the home. The studied also limited its scope to nonsexual violence rather than sexual violence. In this study it was hypothesized that being victimized or witnessing recurring nonsexual violence in the community during the high school years would be

associated with four types of psychological trauma symptoms (anger, anxiety, depression, and dissociation) in late adolescence (Rosenthal, 2000).

The results of the study indicated that exposure to recurring community violence during the high school years is related to a wide range of psychological trauma symptoms, including anger, anxiety, depression, and dissociation (Rosenthal, 2000). The findings indicated that direct victimization and, to a similar extent, witnessing community violence were related to trauma symptoms. There were some differences in PTSD symptomotology based upon the type of exposure to community violence. Witnessing violence was more related to anger; whereas, victimization tended to be correlated with depression (Rosenthal, 2000).

This study is significant to understanding the long-term effects of chronic community violence. The phenomena investigated in this study did not fit the formal diagnostic category of posttraumatic stress disorder as found in DSM-IV (APA, 1994). The correlations in the Rosenthal (2000) study were between the cumulative experience of violence in the community (over a three year period) and trauma symptoms, as opposed to the correlation between a single event and trauma symptoms. The

study revealed that repeated exposure to chronic community violence does result in greater vulnerability to developing PTSD symptoms. This study supports the arguments made by other trauma specialists that repeated exposure to violence might have a cumulative effect upon psychological functioning and development.

Many researchers believe that there should be a separate diagnostic category that captures the complex symptomotology resulting from such "insidious trauma" (Root, 1992; Herman, 1992). The following sections will address the specific symptoms exhibited by youth who have been exposed to chronic community violence.

Urban Violence Traumatic Stress Response Syndrome (U-VTS)

Based upon extensive clinical experience treating inner-city children, Parson (1994) developed the concept of Urban Violence Traumatic Stress Response Syndrome (U-VTS) to complement the DSM III-R diagnostic criteria for PTSD. The diagnostic features of U-VTS offer a more comprehensive and realistic understanding of the responses of low socioeconomic status, ethnic minority youths living in the inner cities (Parson, 1994). Vulnerability to U-TVS involves a range of individual, familial, and societal factors. Parson (1994) pays particular attention to the

some of the systemic socioeconomic and racial stressors which may impact a child's vulnerability to U-VTS. He also identifies the dysfunctional family patterns which may exist in poorer inner-city environments and the effect these patterns have upon vulnerability. Parson (1994) emphasizes that urban children may have been exposed to many stressors prior to a traumatic episode, thus increasing their vulnerability and compromising resiliency and coping mechanisms. His conceptualization of Urban Traumatic Stress Response Syndrome correlates with the findings of other trauma experts by suggesting that chronic community violence as experienced in poorer urban neighborhoods can have a cumulative effect, increasing vulnerability to a range of psychosocial difficulties.

The clinical components of U-VTS as described by Parson (1994) are the following: (a) damaged self syndrome; (b) trauma-specific transference paradigms; (c) adaptation to danger; (d) cognitive and emotional stress response; (e) impact on moral behavior; (f) post-traumatic play; (g) PTSD; and, (g) post-traumatic health outcomes (p. 162).

The damaged self syndrome caused by trauma is described by Parson (1994) as a violent intrusion into the self, its organization, integrity,

and adaptive functioning. The sense of powerlessness over the traumatizing environment creates within the child a sense of insecurity and impotence. Traumatically damaged children appear to be disposed to impulsive actions that harm themselves, and that defensively inflict damage on others. Referring to inner city children struggling with hyperaggressive impulses, Dyson (1990) observed: "Violence, for them, seemed the only way to repair their injured self-esteem" (p. 19). This regulation of self through violence may be a partial explanation of why victims become victimizers (Parson, 1994). For some children, moral development becomes fixated at the more primitive "vendetta" stage (Garbarino et al, 1992).

Parson (1994) identified several indicators of the damaged inner-self structure following urban violence. Among the indicators of damaged inner-self structure following urban violence are: (a) cumulative grief and mourning; (b) feelings of hopelessness and powerlessness; (c) a sense of betrayal and defilement; (d) fears of recurring trauma and violence; (e) the expectation of danger and violence; (f) a loss of future orientation; (g) feelings of incompetence and an external locus of control over life events; (h) a disposition for self-abuse; (i) detachment and loss of bonding

capacity; and, (j) dysfunctional socialization – a reversal of the normal, healthy patterns of interaction with abnormal and disruptive socialization (Parson, 1994, p. 168).

Chronic community violence also results in cognitive and emotional stress responses in children. Parson (1994) describes how there is a marked regression from the formal to post-formal operations thinking, to more concrete operations. One of the chief psychological reactions of children after trauma is intolerance for strong affective tensions. Emotional stress reactions produce serious impairments in self-regulation and in human relationships. Trauma-origin regression (from mature to immature developmental levels) is noted in the child's (a) reversion to intense psycho-physiological symptomotology, irritability, and hyper-vigilance; (b) sleep problems; (c) annihilation anxiety; (d) separation anxiety; (e) panic attacks; (f) phobias; (g) enuresis and encopresis; and (h) the undoing of basic trust (Parson, 1994, p. 170). Extreme or prolonged exposure to threat, danger, and violence may also force a regression from advanced forms of moral reasoning to primitive levels of moral conviction and behavior (e.g., from a rational and beneficial stage to an obedient, punitive, and "vendetta" mentality (Parson, 1994).

Parson (1994) describes how the characteristics of U-TVS combined with chronic community violence can become a lifestyle for many young urban minority youth.

> Violence-based trauma often truncates human connectedness and breaks the great chain of humanity that connects us all. As a consequence of both psychic trauma and the failure of the post-violence milieu to restore confidence, trust, and function in children, many of them become hardened to other people's needs and points of view, adopting an interpersonal anesthetic in the form of cold, tough, aloof, and intimidating street-wise demeanor (p. 171).

PTSD Symptom Profile Caused by Chronic Community Violence

Victims of violence and trauma exhibit a range of symptoms and there is often an overlap between PTSD and other psychological disorders. A variety of factors appear to mediate the relationship between exposure to violence and the severity of symptom expression. These include the particular characteristics of the traumatic event and the individual psychological make-up of the child (Mabanglo, 2002). One predictable mediating factor cited in the research is the relationship between physical and emotional proximity to the trauma, and the severity of the traumatic response. Physical proximity refers to the child's direct involvement in a traumagenic event, either as victim or close witness. There appears to be a "near miss phenomenon" which may predict symptoms (Pynoos et al.,

1987). Intense or prolonged exposure to descriptions and images of trauma contribute to the trauma response. Exposures to secondary adversities such as displacement, relocation, or economic ramifications also contribute to symptom development (Mabanglo, 2002).

The child's relationship to the victim is one of the most powerful factor predicting the development and expression of symptomotology (Mabanglo, 2002). It appears that children are most affected by witnessing violence involving people who are close to them. Familial stressors including prolonged separation from parents have also been found to increase vulnerability to PTSD following exposure to traumatic events. Significantly more PTSD subjects than non-PTSD subjects have experienced early parental separation or divorce (Berton & Stabb, 1996).

Age and developmental stage affect both the symptom profile and severity of PTSD resulting from violence exposure. Following exposure to a school shooting, younger children more commonly experienced avoidant symptoms, while older children suffered more from hyperarousal and re-experiencing (Pynoos et al., 1987). Younger children were also more likely to have spontaneous intrusive phenomena than

older children and adults. Older children and adults typically suffer greater distress in response to specific reminders (Mabanglo, 2002).

Research examining the effects of chronic community violence on young children reveals a prevalence of specific symptoms which clinicians should be aware of (Osofsky, 1995). Following violence exposure, young children may exhibit aggressive behaviors and negative emotions. Several studies indicate that exposure to violence may affect children's ability to regulate their affective states in the future (Pynoos et al., 1996; Osofsky, 1995). Children who have not yet developed the capacity for language exhibit other symptoms of PTSD when exposed to violence. These include disrupted patterns of eating and sleeping, difficulties in attending and relating, anxious reactions, fearfulness, and re-experiencing the trauma (Pynoos et al., 1996; Osofsky, 1995). "Children who are exposed to chronic community violence may withdraw and appear depressed, have difficulty paying attention, or become aggressive" (Osofsky, 1995, p. 785).

For young children, the response of significant adult figures has a profound effect upon their resiliency and capacity to cope with trauma. Chronic community violence can greatly compromise the capacity of parents to adequately care for the emotional needs of their children. "The

parents' or caregivers' ability to deal with their own trauma or grief is extremely important for the outcomes of their children" (Osofsky, 1995, p. 784). For young children exposed to violence, the degree of disturbance depends upon several variables. These include the type of violence, the developmental phase of the child, the family and community context, and the availability of other family members and community supports (Osofsky, 1995; Pynoos et al., 1996).

Adolescents who have been exposed to violence appear to exhibit a different cluster of symptoms than young children and research suggests co morbidity with other psychological disorders. Urban adolescents appear to be at highest risk for exposure to community violence and exhibit high prevalence of PTSD symptomotology, as well as other disorders correlated with violence exposure. In a large study involving more than 3,700 high school students, Singer et al. (1995) found that adolescents exposed to community violence were experiencing a range of psychological difficulties as compared to their classmates. Exposure to violence and victimization were significantly related to the development of post-traumatic stress, anger, depression, anxiety, and dissociation among this group of adolescents (Singer et al., 1995; Mabanglo, 2002).

Mazza and Reynolds (1999) found an intriguing relationship between PTSD symptomotology and other disorders among inner-city adolescents exposed to violence. Their study focused upon exposure to violence in inner-city adolescents and the relationship to suicidal ideation, depression, and PTSD symptomotology. They found that the relationship between violence exposure and PTSD symptomotology remained significant after controlling for depression and suicidal ideation severity. Analysis of their data suggested that PTSD symptomotology may function as a mediating variable between exposure to violence and other mental health outcomes, such as depression and suicidal ideation (Mazza & Reynolds, 1999).

There appears to be gender differences in the level of violence exposure and subsequent PTSD symptomotology among urban adolescents. Berton and Stabb (1996) found that African American males were exposed in their neighborhoods and schools to more violent crime than any other group. Their study also revealed a significant difference in the symptom severity experienced by girls as opposed to boys. Girls obtained the highest PTSD scores of all participants in the study, indicating that girls may respond to violence with more symptoms of

PTSD than boys (Berton & Stabb, 1996). Jenkins and Bell (1993) found that male and female students responded very differently to violence exposure. They found that: (a) boys were much more negatively impacted by victimization than girls; (b) girls were more negatively affected by witnessing violent events than boys; (c) girls had much higher scores than boys on psychological distress measures related to violence exposure; and (d) the correlation between trauma exposure and risk-taking behavior was much higher among boys than girls.

The study by Berton & Stabb (1996) indicated that the single variable found to be predictive of PTSD was self-reported exposure to domestic or community violence. Actual demographic statistics of violence in the vicinity was not as reliable a predictor of PTSD symptoms as self-reported exposure to violence. This finding supports other research which suggests that physical and emotional proximity are related to PTSD symptomotology (Mabanglo, 2002). Attachment to the victim, and the personal meaning associated with the violence, appear to have a significant relationship with the prevalence and severity of PTSD symptoms.

Another mediating factor involves perceptions of hope, and perceived vulnerability to victimization. A correlation was found between violence exposure and perception of hope and vulnerability to victimization. The highest level of hope was seen in adolescents who had witnessed violence but had not experienced it personally. Perceived vulnerability to victimization was most prevalent among adolescents who had been personally exposed to very high levels of violence (Mabanglo, 2002). This research supports the hypothesis that exposure to violence can have a cumulative detrimental effect on psychological functioning.

Chronic Violence, Complex Trauma and Intergenerational Trauma

Many trauma experts suggest that there should be a separate diagnostic category for individuals who have been exposed to repeated long-term insidious violence and trauma (van der Kolk, 1996; Herman, 1992; Root, 1992; Terr, 1990). Several clinicians experienced in working with traumatized youth and adults argue that survivors of prolonged trauma and violence exhibit qualitatively different symptom profiles than individuals who have been exposed to single-episodic trauma. Root (1992) describes "insidious trauma" – which are less salient, less dramatic, "smaller" events that have a cumulative effect. Based upon extensive

clinical experience with traumatized youth, Terr (1990) distinguished between Type I and Type II stressors, and related posttraumatic symptoms. Type II childhood PTSD results from a series of traumatic events or from exposure to a prolonged traumatic stressor. Characteristics of this type of PTSD are: denial, dissociation, and numbing. Diagnostically, Type II stressors tend to produce a diversity of psychiatric disturbances rather than a coherent syndrome.

Herman (1992) and others have argued for the recognition of a complex traumatic syndrome caused by chronic abuse and/or prolonged exposure to violence. Diagnostically, individuals with complex traumatic syndrome present the following history of prolonged abuse and/or exposure to violence:

> A history of subjection to totalitarian control over a prolonged period of time (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation (Herman, 1992, p. 121)

Characteristics of this complex traumatic syndrome include: alterations in affect regulation, self-perception, and relations with others (Herman, 1992, p. 121). This complex trauma syndrome appears to be

more deeply ingrained in the personality structure of the individual than the symptoms of PTSD caused by a single traumatic event. Individuals suffering from complex PTSD often experience tumultuous interpersonal relationships, similar to the relational patterns experienced by individuals with borderline personality disorder. "The chronically abused person's apparent helplessness and passivity, her entrapment in the past, her intractable depression and somatic complaints, and her smoldering anger often frustrate the people closest to her" (Herman, 1992, p. 115)

The chronic community violence, which many minority youth are exposed to on a regular basis, resembles the totalitarian, prolonged violence described by Herman(1992) and Terr (1990) in their respective typologies of PTSD. Allen (1996) makes the same comparison in his analysis of PTSD among African-Americans.

> Herman's discussion of complex PTSD, or PTSD in those who have sustained abuse, stirs important questions relevant to the understanding of African American patients. All of the factors of extreme political and social oppression have been in force until the very recent past. More recently, the politics of deprivation have created traumagenetic life circumstances in which disproportionate numbers of African Americans act out against each other, especially in male-to-female violence and youth violence (Allen, 1996, p. 227).

The conceptualization of intergenerational posttraumatic stress disorder is relevant to PTSD among urban African American youth and the propensity towards violence in these populations. A large percentage of ethnic minority groups in the United States have been subjected to prolonged, systemic oppression either in their native county or within the U.S. Such pervasive oppression can become inextricably woven into the collective self-concept of an entire ethnic group and transmitted across generations. The concept of intergenerational PTSD began with research done with victims of the Nazi Holocaust. Findings indicated that children of Holocaust survivors, who did not witness any of the atrocities first hand, exhibited posttraumatic symptoms later in life. Duran (1995) argues that Native Americans have suffered equivalent intergenerational oppression and loss, and as a result, exhibit symptoms of intergenerational posttraumatic stress. "This integration of the oppressor by the personality does not occur overnight; it has been systematically interwoven into the fabric of the Native American family for generations" (Duran, 1995, p. 30). Similarly, Herman (1992) found that psychiatrists who treated Southeast Asian refugees also recognized the need for an "expanded concept" of posttraumatic stress disorder that takes into

account severe prolonged, and massive psychological trauma. Similarly Parson's (1994) conceptualization of urban violence traumatic stress as experienced by African American children living in inner cities suggests a pervasive violent culture.

> The list of psychological reactions is long and grim: hatred for self, profound loss of trust in the community and the world, tattered internalized moral values and ethics of caring, and breaking down of the inner and outer sense of security and reality" (p. 158).

Researchers have equated the urban neighborhoods where many minority youth live to "war zones" (Bell & Jenkins, 1993). The research seems to indicate that some of these neighborhoods do resemble war zones for the youth living there. "Normal" childhood development should not include a 97% chance of witnessing community violence, a 70% likelihood of being victimized by some form of community violence, and a 25% chance of witnessing a shooting. Sadly, these war-like statistics come from the neighborhoods and schools which have a predominance of minority youth.

When such community violence is chronic, children's normal coping mechanisms become compromised. Hypervigilance seems like an adaptive response when homicide is the leading cause of death for your particular ethnic age group (as is the case for African-American

adolescents). The intergenerational transmission of trauma can become systematically interwoven into the culture (Duran, 1992). The oppressed can become the oppressor in his own community. This can be compounded by the long-term effects of trauma which produce the compulsion to repeat the trauma through future victimization and perpetration of violence (van der Kolk, 1996). Urban minority youth seem most vulnerable to becoming inextricably caught in this viscous cycle of trauma and violence.

Resiliency & Survival

Youth Resiliency & Protective Factors

Early Studies on Resiliency

In the 1950s there was a small body of research that began which focused on assets in individuals and systems rather than on deficits. This shift from studying childhood risk factors to examining resilient qualities has gained increased attention in psychological and educational research. One longitudinal study conducted by Garmezy and Rutter (1983) focused on more than 200 children in urban settings in the United States. Studying these children over time, the researchers noticed a similar pattern: the majority of children, despite the high risk environments in which they grew up, developed into healthy, conventionally defined "successful" young adults. Longitudinal studies have concluded that most children seem to have self-righting tendencies and that competence, confidence and caring can flourish even under adverse circumstances (Werner, 1990; Garmezy & Rutter, 1983). "Positive relationships rather than specific risk factors seemed to have a more profound impact on the directions that individual lives take and that it appears that it is never too late to change a life trajectory" (Howard, Dryden, & Johnson, 1999, pp. 309-310).

Several conceptualizations of what constitutes resiliency have been proposed by researchers. Bernard (1991) defines resiliency as a set of qualities, or protective mechanisms that give rise to successful adaptation despite the presence of high risk factors during the course of development. Linquanti (1992) presents a similar definition. Resilience is:

> That quality in children who, though exposed to significant stress and adversity in their lives, do not succumb to the school failure, substance abuse, mental health, and juvenile delinquency problems they are at greatest risk of experiencing (Linquanti, 1992, p. 2).

Masten, Best, & Garmezy (1990) identify three distinct types of resilience. First, they identify the "overcoming odds" type of resilience which refers to the belief that individuals have a particular quality or personal strength that enables them to withstand adversity. Secondly, resiliency can refer to coping in the face of sustained and acute negative circumstances (e.g., continuous family conflict). Thirdly, it can refer to recovery from trauma (e.g., the death of a parent). They caution, however, that resiliency should not be conceptualized as a discrete quality which children either possess or do not possess. "Children may be more or less resilient at different points in their lives depending on the interaction and accumulation of individual and environmental factors" (Howard et al., 1999, p. 310).

Over the course of research, more specific attributes have been identified which contribute to the general quality termed *resiliency*. The more specific attributes that have emerged from this general description identify not only the internal assets of the individual but also external strengths occurring within systems in which the individual grows and develops; both are frequently referred to in the literature as *protective factors* (Howard et al., 1999). As with risk factors, protective factors appear to have a cumulative effect. Therefore, the more protective factors present in a child's life, the more likely they are to display resilience.

Rutter (1990) further proposes that resiliency be conceived in terms of dynamic processes rather than pre-defined factors or variables. "The search is not for broadly defined protective factors but rather for the developmental and situational mechanisms involved in protective processes" (Rutter, 1990, p. 183). He has identified four types of protective processes: those that reduce risk impact or reduce a person's exposure to risk; those that reduce negative chain-reactions that follow bad events or experiences; those that promote self-esteem and self efficacy through achievements; and, positive relationships and new opportunities that

provide needed resources or new directions in life (Rutter, 1990; Howard et al., 1999).

Internal Assets & Characteristics of Resilient Youth

The research on protective factors has consistently identified specific internal assets which describe common characteristics of the resilient child. These internal assets include: social competence, problem solving skills, autonomy, and a sense of purpose and a future (Garmezy, 1985; Rutter, 1984; Masten et al., 1990). Rutter (1984) describes social competence in terms of adaptability and social problem solving in terms of children's ability to think (and operationalize) a range of solutions to social problems. The internal asset of a sense of purpose and future consists of aspiration and a sense of usefulness (Masten et al., 1990). The asset of autonomy concerns self-esteem, self-efficacy and mastery beliefs (Rutter, 1984; Masten et al., 1990). Rutter (1984) expands upon the sense of self-esteem and self-efficacy as:

> A feeling of your own worth, as well as a feeling that you can deal with things, that you can control what happens to you. One of the striking features of problem families is that they feel at the mercy of fate, which is always doing them an ill-turn. So one important quality is a feeling that you are in fact master of your own destiny (Rutter, 1984, p. 60).

Resilient youth also approach stress and trauma differently than more vulnerable youth. When confronted with stress, resilient youth attempt to master the stress rather than retreating from or defending against it (Anthony & Cohler, 1987). Resilient children are able to manipulate and shape their environment; they adapt quickly to new situations, perceive what is occurring, act flexibly and view themselves in a positive way (Garbarino et al, 1992). These youth also have the capacity to make sense of stressful and traumatic events confronting them. Anthony and Cohler (1987) describe this ability to understand clearly what is occurring in the environment as "representational competence." This characteristic trait of "representational competence" helps children master stress and make sense of threatening experiences.

External Assets & Environmental Protective Factors

External assets have been described in relation to three primary systems in the child's world: family, school, and community. Several protective factors identified in relation to the family relate to the consistency and quality of care and support the child experiences during infancy, childhood, and adolescence (Howard et al., 1999). A secure

attachment relationship with the caregiver during infancy is a critical family protective factor which impacts resilience throughout future development. A caregiver who is accepting, sensitive, available, and responsive gives the child a strong feeling of security, confidence, and contributes to resilience (Anthony & Cohler, 1987). The attachment relationship is a potent determinant of a child's emotional, social, and cognitive development (Garbarino et al., 1992; Garmezy & Rutter, 1983).

Several studies have identified specific family characteristics that function as protective factors for children. Empirically based data on family protective factors point to the importance of the following qualities: adequate and consistent parental role models and harmony between parents; parents who spend time with children in order to pass on verbal and social attainments; parents who provide for and take interest in constructive use of leisure; and, parents who provide firm and consistent guidance without repressive or rejecting attitudes (Howard et al., 1999; West & Farrington, 1973). Werner and Smith (1988) identified additional protective factors in relation to the family. These included family size (four or fewer children) and the availability within the household of care-givers — apart from the mother — who were prepared to provide

substantial amounts of attention to the child in infancy. Family cohesion and the mother having a manageable workload were also identified as protective factors. Familial protective factors during adolescence included structure and rules, as well as an informal and multigenerational network of kin and friends. Few chronic, stressful life events experienced during childhood and adolescence further fostered resiliency. A major longitudinal study of 1400 families attempted to identify strengths that contribute to family resiliency in times of stress (McCubbin, H., Thompson, Pirner, & McCubbin, M., 1988). According to their research, resilient families seem to have three particular characteristics in common. First, they have a system of celebrations and acknowledgements of key events in the life of the family that have a stabilizing effect during times of crisis (e.g., celebrating birthdays and holidays). Secondly, family members have strong, durable beliefs in their ability to control life. Thirdly, the family establishes and maintains routines for a variety of activities (e.g., specific times for meals, going to bed, completing chores).

A second external asset which has been identified as a potential protective factor is the *school environment* (Rutter, 1984). Children who may come from disadvantaged homes can demonstrate resilient

characteristics if they attend schools that have good academic records and attentive, caring teachers. Schools can provide children with positive experiences that are associated with either success or pleasure. Teachers can also play an important role in promoting resiliency in children. Several studies indicate that among the most frequently encountered non-family, positive role models in the lives of resilient children were favorite teachers who took a personal interest in them, were not just academic instructors but were also confidants and positive models of personal identification (Howard et al., 1999; Werner & Smith, 1988). Research suggests that school reform is needed to promote those factors that have been shown to predict resilience in student populations; however, such reform remains based on resilience factors remains rare (Rutter, 1994).

The third social system identified as a source of external assets is the *community*. Children from disadvantaged areas are generally considered more at risk than those in more affluent areas. However, even in disadvantaged areas, certain community characteristics seem to operate as protective factors. Social support from the community can be a potentially potent protective factor in the lives of children and adolescents. Social support has been defined as "information leading the

subject to believe that he/she belongs to a network of communication and mutual obligation" (Cobb, 1976). Social support systems that act as protective factors in the lives of children are extended family, friends, neighbors, and teachers who provide emotional support, encourage self-esteem, and promote competence (Garbarino et al., 1992). This network of individuals is most effective when they can supply a caring, stable and structured environment for the child (Werner, 1990).

Several researchers argue that caring and support across all three external systems – family, school and community - is the most critical variable throughout childhood and adolescence (West & Farrington, 1973; Rutter, 1984; Germezy, 1985; Masten et al., 1990). Consistent caring and support establish the basis for trusting relationships throughout life, which was identified earlier by Erikson (1963) as the foundation for healthy future development. These studies represent the internal and external protective factors which promote resiliency in children across cultural and socio-economic groups. The following section will address protective factors which have been identified as promoting resiliency among youth living amidst community violence.

Many of the protective factors which have been identified in past literature on childhood resiliency are consistent protective factors against the negative effects of community violence. However, there does appear some variability in certain domains. Additionally, some factors previously identified as promoting resilience may in fact increase risk vulnerability for inner-city youth. This section will present the findings from specific studies on the internal assets which are characteristic of resilient urban youth and the external assets which may buffer the spectrum of negative affects caused by exposure to chronic community violence.

Internal Assets & Personality Characteristics

Unique individual characteristics have been identified among urban youth who appear to be more resilient to the effects of community violence than their stress-affected peers. Luthar & Zigler (1991) examined the protective factors that allow inner city adolescents to maintain socially competent behavior despite stress. Moderator variables examined included intelligence, internal locus of control, social skills, ego development, and positive life events. Their study indicated that various

aspects of personality were involved in three areas: protective, vulnerability, and compensatory processes. These protective processes, in turn, modified the effects of life stresses.

Internal locus of control, or the belief that forces shaping one's life are largely within one's own control, was found to be involved in protective processes. In contrast, those youth with an external orientation showed greater declines in functioning as stress levels increased. This finding is consistent with theories of learned helplessness (Werner & Smith, 1988) and Rutter's (1990) observation that autonomy and self-efficacy are critical internal assets. Luthar's (1991) study also found that interpersonal skills were protective against stress; and, specifically, social expressiveness was found to be statistically significant.

Interaction effects between intelligence and stress indicated that intelligence was involved as a vulnerability mechanism (Luthar, 1991). At low levels, intelligence was positively related to competence. However, when stress was high, intelligent children appeared to lose their advantage and demonstrated competence levels similar to those of less intelligent children. Although, previous studies indicated that intelligence protects against stress (Garmezy & Rutter, 1983), findings from other

studies are consistent these results (Masten et al., 1990). It has been suggested that more intelligent children tend to have higher levels of sensitivity to their environments (Zigler & Farber, 1985). This sensitivity may result in higher susceptibility to stressors among brighter children compared to less intelligent children. The cumulative effects of environmental stressors may also impact children's capacity to utilize their intellect. Related studies indicate that trauma significantly impairs intellectual functioning and concentration (van der Kolk, 2003; Pynoos & Eth, 1985).

Ego development was found to be a robust compensatory factor (Luthar, 1991). This finding is consistent with earlier studies establishing that ego development is a significant concomitment of various aspects of adjustment and metal health (Browning & Quinlan, 1985; Noam, 1984).

Interestingly, several studies indicate that even "resilient youth" have a high level of internalizing symptoms including depression, anxiety, and somatization (Dubrow & Ippolito, 2000; Luthar & Zigler, 1991). D'Imperio, Dubow, & Ippolito (2000) compared resilient and stress-affected inner-city adolescents. In their study, both resilient and stress-affected youth experienced equivalent levels of internalizing symptoms,

and these groups' scores were higher than those of low-stress participants. Luthar (1991) also examined the psychopathology found among children identified as resilient and concluded the following:

> Evidence that resilient youth…were significantly more depressed and anxious than competent youngsters from low stress backgrounds suggest that while the type of problems developed may vary, some type of difficulties may inevitably be associated with severe life stressors (Luthar, 1991, p. 613)

Therefore, chronic stressors such as community violence may take a toll on the majority of youth; however, the manifestation of its negative impact may be less obvious or problematic among some youth. This finding is relevant to clinicians, who may overlook children who appear resilient, but who may actually be susceptible to severe internalizing symptoms which remain unnoticed and undiagnosed.

External Assets & Environmental Protective Factors

The external assets which function as protective factors involve the various social systems which children are involved in. These areas include the following systems: family, school, peer relationships, and the surrounding community. There are several similarities between external assets identified in previous literature on resilience and the protective factors specific to children exposed to community violence. However,

research on resilience related to community violence indicates that certain social systems may not be as protective, or may provide a different protective function. Studies have even found that some social systems identified as protective factors in previous resiliency studies – such as peer support – can in fact be deleterious for children living amidst chronic community violence (O'Donnell, Schwab-Stone, Muyeed, 2002). This section will present research relative to the external protective factors which appear to buffer the negative affects of community violence.

As with previous studies on childhood resiliency, family functioning was found to be a critical protective factor for children living in violent communities. The adult caregiver response to danger or crisis has been found to moderate the development of posttraumatic symptoms in children exposed to community violence. When the caregiver is calm and effective in the face of danger, without minimizing the seriousness, the prognosis is much better then when the parent is either absent or overwhelmed (Pynoos et al., 1996). Martinez and Richters (1993) found that violence exposure was more strongly correlated in children of less educated mothers. A second study by found that children living in unstable or unsafe homes demonstrated significantly higher rates of

social, emotional, and academic problems after exposure to community violence (Richters & Martinez, 1993). Family structure has been found to moderate the relation to both aggression and anxiety or depression for youth exposed to community violence (Gorman-Smith et al., 1996).

Gorman-Smith, et al. (1996) examined the role family function has in moderating risks associated to community violence among African American and Latino males living in inner-city environments. They found that youth from struggling families – those that consistently used poor parenting practices and had low levels of emotional cohesion – were more likely to be exposed to community violence. They also found a relationship between family functioning, exposure to violence, and future perpetration of violence. Youth exposed to high levels of community violence but living in families that functioned well across multiple dimensions of parenting and family relationship characteristics perpetrated less violence than similarly exposed youth from less well-functioning families.

Family functioning appears to affect the risk or resiliency of youth in several domains related to community violence. Family stability and predictability can reduce levels of violence exposure. Similarly, positive

family functioning can mediate the affects of exposure to community violence. In addition, poor family functioning has been associated with delinquency (Rosario et al., 2003), and perpetration of violence (Gorman-Smith et al., 1996) for those youth exposed to high levels of community violence. Therefore, when there is positive family support it may function as a protective factor against many risks associated with community violence; however, when there is poor family functioning it can potentially serve as contributor or catalyst to multiple violence related risks.

Peer relationships are another social system which can function as either a protective factor or contribute to risk among youth exposed to community violence. O'Donnell et al. (2002) conducted a study of the multiple domains of resilience among 2,600 sixth, eighth, and tenth graders exposed to community violence. In their study they found that peer support was negatively associated with resilience in the domains of substance abuse, school misconduct and delinquency. Rosario et al., (2003) found that peer support moderated the relation between exposure to community violence and delinquency; and, there were both benefits and risks with respect to delinquent behavior. Support from peers buffered the

effects of witnessing community violence on the delinquent behavior in boys, but peer support amplified the effects of victimization on both boys and girls.

The broader social contexts of school and community can be sources of several protective factors which promote resiliency. Unfortunately, these environments can also be major source of the risk factors related to both the perpetration of community violence as well as the subsequent negative effects of such exposure. A critical external; protective factor which both of these environments can potentially provide is a caring adult. Research findings suggest that regardless of the nature or extent of hardship to which a child is exposed, the presence of a warm and caring adult inevitably serves a protective factor (Luther & Zigler, 1991; Werner, 1990). Victims of childhood adversity who identify at least one supportive adult from their past demonstrate a broad range of resilient and adaptive capacities compared to their less supported counterparts, including: less violent behavior, higher academic achievement, better coping skills, a more positive self-images, and an overall improvement in psychological well-being, level of functioning,

and quality of life (Werner & Smith, 1988; Rutter, 1984; Wolkow & Ferguson, 2001).

Some researchers examining risk and resiliency among inner-city youth have applied strengths-based approaches towards fostering resilience. Researchers have documented positive growth that can result from a range of problems, including abuse, family disruption, delinquency, health problems, and natural disasters (McMillan & Fischer, 1998).

> Without minimizing the destructive impact of these events, humans have a remarkable potential for survival and healing. In the most difficult problem lies some opportunity for growth (Brendtro & Shahbazian, 2003, p. 9)

Based upon related research on resiliency and extensive work with at-risk youth, Brendtro, Brokenleg & Van Bockern (2002) have identified certain critical qualities which children need to overcome adversity and experience healthy and meaningful development. They suggest what all children need in order to experience what they call the Circle of Courage: environments of belonging, mastery, independence, and generosity.

> To create these environments of courage even in the shadows of problems, efforts are focused on helping kids feel a sense of attachment (belonging), competence (mastery), power

> (independence), and worth (generosity) (Van Bockern, Wenger & Ashworth, 2004, p. 149)

As Rutter (1994) advocates, protective processes should not be conceived of as a list of factors, or ingredients, which produce resilient youth. Instead, resiliency is a dynamic process, affected by the people and systems which interact with youth. It is the onus of the mental health profession to implement interventions which foster such protective processes. The research on resiliency suggests that mental health professionals need to operate from a strengths-based model rather than a deficit model when working with these youth.

> What we want to achieve in our work with young people is to find and strengthen the positive and healthy elements, no matter how deeply they are hidden. We enthusiastically believe in the existence of those elements even in the seemingly worst of our adolescents (Wilker, 1920).

Positive Growth Following Trauma

There is considerable research documenting positive growth following adversity and trauma. Adversity and trauma do not always produce deleterious outcomes, and can conversely, be catalysts for positive growth and change in certain individuals. "It is through this process of struggling with adversity that changes may arise that propel

the individual to a higher level of functioning than that which previously existed prior to the event" (Linley & Joseph, 2004).

Studies comparing a variety of adversarial conditions have distilled common characteristics which may foster positive rather than detrimental outcomes. Linley & Joseph (2004) compared 39 empirical studies documenting positive change following trauma and adversity. There was a broad range in the types of trauma and adversity examined in these studies, including: chronic illness, AIDS, rape, plane crashes, military combat, and recovery from substance addiction. Comprehensive comparison revealed certain characteristics which were consistently associated with adversarial growth, while there were inconsistent findings related to other variables across the different studies.

Cognitive appraisal variables were consistently associated with adversarial growth. Greater levels of perceived threat and harm were associated with higher levels of adversarial growth (Linley & Joseph, 2004). Researchers have argued that the potential for growth is greatest following exposure to extraordinary traumatic life experiences (Tedischi & Calhoun, 1995). In relation to cognitive appraisal, awareness and

controllability of the traumatic event were also associated with higher levels of adversarial growth.

There were socio-demographic variables which tended to predict adversarial growth. Some evidence suggests that women tend to experience higher levels of adversarial growth than men, although these findings are mixed. Younger respondents tended to report more adversarial growth once a given level of developmental maturity was achieved.

Certain personality characteristics were associated with growth following trauma and adversity. Among these characteristics were: extraversion, openness to experience, agreeableness, and conscientiousness. Self-efficacy and hardiness were also associated with adversarial growth. People with higher-self esteem and who were more optimistic tended to report more growth.

Coping strategies which involved positive interpretations of the experience tended to promote positive growth. Problem-focused coping, as well as acceptance, positive reinterpretation, and positive religious coping were positively associated with growth. Emotion-focused coping, such as emotional social support, was associated with positive growth.

Religious activities and intrinsic religiousness were both associated with growth following adversity or trauma.

There were other environmental and psychological factors which contributed to positive growth, or exacerbated negative outcomes. Rumination, intrusion, and avoidance were all associated with positive growth. An explanation for this surprising finding is that these characteristics are indicative of the cognitive processing necessary for the rebuilding of shattered views following trauma (Calhoun & Tedeschi, 1998; Linley & Joseph, 2004). Positive affect was consistently positively associated with growth, whereas negative affect hindered positive growth. Mental health diagnoses such as depression, anxiety, and PTSD were not associated with perceived positive growth. Adolescents who used more alcohol, tobacco, or marijuana were less likely to report posttraumatic growth.

The comparative literature review and analysis by Linley & Joseph (2004) clearly demonstrates that positive life changes and growth can occur following adversity and trauma. Research suggests that there are several intrinsic and external factors which impact the level of adversarial growth. The subjective perceptions of the individual appear to

significantly influence the potential for growth. This section presented a broad examination of the different variables which influence adversarial growth. The next section will present the findings of a study specifically focused upon positive growth following exposure to community violence.

Predictors of Positive Growth Following Community Violence Exposure

As with other adversity, the traumatic effects of community violence may yield positive growth in certain individuals. A study of 258 physically injured survivors of community violence identified certain longitudinal predictors of perceived growth (Updegraff & Marshall, 2005). Analyses indicated that perceived growth at follow-up was positively linked to situation-specific optimism, dispositional optimism, and initial symptoms of trauma-related distress. The findings from this study suggest that initial trauma-related distress, as well as initial optimistic tendencies, may play a direct role in perceived growth following adversity.

The study conducted by Updegraff & Marshall (2005) was unique because their study separated objective trauma severity from subjective distress. They found that objective severity was not as strong a predictor

of positive growth as was subjective distress. “Posttraumatic growth is associated with the degree of psychological disruption – as measured by posttraumatic distress – rather than with objective injury severity” (Updegraff & Marshall, 2005, p. 553). Additionally, individuals who were most symptomatic shortly after trauma exposure were among those most likely to report personal growth at 3-month follow-up.

Optimism was also found to be a critical factor in perceived growth following trauma caused by community violence. In this study, optimism was examined as a contributing factor in different aspects. Dispositional optimism significantly predicted subsequent growth. The study also found that situation-specific optimism predicted perceived growth. Thus, perceived growth varied as a function of the degree to which individuals initially expected that something positive would occur as a result of exposure to adversity.

From a clinical perspective, these findings are especially important, because clinicians should be aware of the potential for positive change in their clients following trauma and adversity. Interventions for posttraumatic stress disorder typically do not take into account the potential for adversarial growth. Positive changes can be foundations for

therapeutic work, providing clients with the hope that they may overcome their trauma. Clinicians may be able to harness context-specific optimism to foster resiliency and recovery. Initially distressful posttraumatic responses may not be warning signs of future pathology; but rather, may prove to be catalysts for positive change and growth.

CHAPTER THREE: RESEARCH QUESTION & RATIONALE

The question this research study addressed was, "How does chronic community violence effect urban youth; and, what are the resources which help them cope and survive?" The four research topics which were examined in relation to this question are:

Levels of exposure to community violence

Trauma-related factors, including diagnoses and symptoms

Resilient qualities which help urban youth cope (individual and environmental).

The interaction between community violence and processes of risk and resiliency.

This study used a mixed-method research approach applied to a multiple case study design. Twelve youth ages 12-18 years-old, who have been exposed to varying degrees of community violence participated in the study. The study sample was mixed gender and ethnicity. The diversification of the study sample was intended to provide the maximum variation in experiences and perspectives pertaining to the research question.

The quantitative portion of the study included the following standardized assessments: Children's Exposure to Community Violence Survey (CEVS) (Richters & Martinez, 1998), and the Children's Posttraumatic Stress Inventory (Saigh, 2004). The CESV provided data related to the type and frequency of violence exposure each participant experienced. The Children's Posttraumatic Stress Inventory consisted of a structured interview protocol which can be used for both clinical and research purposes. This instrument yields PTSD diagnose based upon DSM-IV criteria. These tests provided data related to how community violence exposure may relate to PTSD symptoms and diagnoses, both within each individual case and compared across case studies.

The qualitative component of the study involved semi-structured interviews with each participant. The intention of the interviews was to elicit each participant's subjective experience of community violence and how it has affected different areas of their lives. Additionally, the interview asked each participant to identify ways in which they have learned to cope with these disturbing experiences. Thus, the qualitative component of the study asked participants to answer, in their own words, the research question of the study, "How does community violence affect

your life, and how have you been able to deal with these upsetting experiences?"

There are several rationales for conducting this study utilizing the proposed methodology. As the expansive literature review demonstrates, the causes and consequences of community violence are extremely complicated, as are the elements of resiliency which help youth cope and survive. Mixed-method designs have been recommended when addressing a problem that is present in a complex social context (Tashakkori & Teddlie, 2003). Many research studies addressing community violence found associations with isolated symptoms or predictors of violence exposure. Although these methods may yield more statistically sound results, the comprehensive "whole picture" may be lost. Qualitative research methods can be particularly useful for obtaining a more holistic understanding of an experience or phenomenon (Creswell, 1998).

Most community violence studies have focused upon the negative consequences of violence rather than the resilient qualities of the young survivors. The few studies which have addressed resilience and community violence have been quantitative in nature. In other words,

recent resiliency studies have isolated key protective factors common to these youth. This contradicts the recommendations of Rutter (1984) that resiliency be viewed as a protective process rather than a predefined list of factors. It is also very important to consider if there are other criteria which youth, as opposed to adults, use to judge risk or resilience. As Winbourne and Dardaine-Ragguet (1993, p. 195), state: “A major shortcoming of many studies is the apparent disregard for viewpoints of children targeted in the research.”

Community violence is not a trifling topic for inner-city youth. For many it affects them at the core of their being and is an ever present threat looming over them. Community violence kills, and for many youth it kills people very close to them, and it is a very real threat to their life and future. It seems only fair that we allow them to share, in their own words, what they think and feel about the violence which surrounds them. As clinicians we should listen attentively because these youth may give us insight into how to help, and how to support their resilient desire to survive, cope and thrive.

CHAPTER FOUR: METHODOLOGY

This study involved mixed method research analysis of a collective case study. Mixed method research designs can be defined as "the collection or analysis of both qualitative and quantitative data in a single study in which the data are collected concurrently or sequentially, are given a priority, and involve the integration of the data at one or more stages in the process" (Creswell, Plano Clark, Gutman, & Hanson, 2003, p. 212). The mixed method model used in this study is based upon the transformative concurrent (or parallel) mixed-methods design. The transformative mixed-methods design has been defined as any research project that uses mixed methods with a goal of social change at levels ranging from the personal to the political (Creswell, 2002) This study had a qualitative emphasis with complementary quantitative data, which is referred to as a nested mixed methods design (Hanson, Plano Clark, Creswell, J.W., Creswell, J.D., 2005). Several cases were examined in this study and the results integrated, which is referred to as a collective case study (Stake, 1995).

Several rationales have been proposed for the use of mixed-method research designs. Greene, Caracelli, & Tashakkori (2003) identified several reasons for combining data collection methods and provided relevant terms for these rationales. Specifically, quantitative and qualitative methods could be combined to use results from one method to elaborate on results from the other method (complementary), use results from one method to help develop or inform the other method (development), recast results from one method to questions or results from the other method (initiation), and extend the breadth or range of inquiry by using different methods of different inquiry components (expansion). Recently, researchers have expanded these reasons and suggested that mixed methods investigations may be used to (a) better understand a research problem by converging numeric trends from quantitative data and specific details from qualitative data; (b) identify variables/constructs that may be measured subsequently through the use of existing instruments or the development of new ones; (c) obtain statistical, quantitative data and results from a sample of a population and use them to identify individuals who may expand on the results; and (d) convey the needs of individuals

or groups of individuals who are marginalized or underrepresented (Mertens, 2005; Hanson et al., 2005).

A mixed method design was appropriate for the present study for several reasons. The current study applied mixed methods research strategies to: a) complement data from each approach; b) expand upon results obtained from one method; and c) broaden the breadth of inquiry (Greene et al., 2003). Inner-city youth tend to be marginalized for a multitude of reasons including age, socio-economic status, and race/ethnicity. Therefore, the subjects in the current study might benefit from the potential of mixed methods studies to convey the needs of groups who are marginalized or underrepresented (Mertens, 2005) The breadth of explanations for the recent escalations of community violence indicates the complexity of this destructive social phenomenon. According to Tashakkori & Teddlie (2003), mixed method designs can be particularly useful when addressing a problem that is present in a complex social context.

Hanson et al. (2005) have classified specific mixed method research designs and procedures for data collection and analysis. The present study involved concurrent data collection because quantitative and qualitative

data were collected at the same time rather than in sequential phases. This study is most aligned to the parameters of a concurrent, nested transformative research design. In concurrent nested designs, priority is usually unequal and given to one of the two forms of data – either quantitative or qualitative. The nested, or embedded, forms of data are usually given less priority. According to Hanson et al. (2005), nested studies are useful for gaining a broader perspective on the topic at hand and for studying different groups, or levels, within a single study.

Based upon the mixed method classification of Hansen et al. (2005) this study is considered a concurrent nested research design with quantitative data embedded within qualitative data. The quantitative component of this study involved administration of standardized assessment instruments to research subjects. Due to the small sample size, statistical analysis of quantitative data would be inconclusive. Consequently, results from standardized measures are descriptive and used to augment qualitative data. Qualitative research consisted of semi-structured interviews of subjects following administration of standardized assessments. Priority was given to qualitative data and the design adhered to primarily qualitative analysis procedures. However, quantitative data

collected was be integrated with the qualitative data obtained for each research subject.

This study utilized a collective case study design, in which multiple cases are studied. Case study research is a useful approach to examine a topic which has not been fully explored; or a complex subject which requires in-depth exploration of unique attributes. There has been some debate over the classification of case study approaches in research, with some considering "the case" an object of study (Stake, 1995) and others who argue that it is a methodology (Merriam, 1988). Stake (1995) argues, "The more the object of study is a specific, unique, bounded system," the greater the rationale for calling it a case study (p. 436). A case study is considered an exploration of a bounded system over time through detailed, in-depth data collection involving multiple sources of information rich in context (Cresswell, 1998). The bounded system of a case may constitute a program, an event, an activity, or individuals. "The context of the case involves situating the case within its setting, which may be a physical setting or the social, historical and/or economic setting for the case" (Creswell, 1998, p. 61). Merriam (1988) states:

> A case study is employed to gain an in-depth understanding of the situation and meaning of those involved. The interest is in process

> rather than outcomes, in context rather than a specific variable, in discovery rather than confirmation. Insights gleaned from case studies can directly influence policy, practice, and future research (p. 19)

A multiple case study design was used in order to capture both unique case specific attributes as well as themes consistent across multiple cases. Miles and Huberman (1994) suggest that using several unique cases, power can be gained to support potential theories, and external validity is enhanced. Qualitative data emerging from a collection of cases keeps intact a focused and bounded phenomenon embedded within its context. As Stake (1995) warns that caution should be taken not to lose that which is unique about a case in an effort to find similarities with other cases. To avoid such over generalizations, this study examined individual cases for unique themes, patterns, and experiences. Following within-case analysis, cross-case analysis was conducted to identify common attributes and themes. Thus, cases were examined for unique and common qualities which may inform the research questions of the study.

This study was based upon a transformative philosophical paradigm. In a transformative paradigm, primacy is given to the value-based and action-oriented dimensions of different inquiry traditions (Greene et al., 2003). Mixed method research designs based upon a

transformative paradigm combine qualitative and quantitative methods to promote change at any level (Creswell, 2002). "The transformative paradigm stresses the influence of social, political, cultural, economic, gender and disability values in the construction of reality" (Mertens, 2005, p. 23). Transformative designs deliberately seek underrepresented or marginalized populations (Mertens, 2005). Concurrent transformative designs use an explicit advocacy lens. Qualitative and quantities data are collected at the same time, and priority may be unequal. One type of research data may be embedded in another, as in nested mixed-method designs. In concurrent transformative designs, data analysis is usually separate, and integration usually occurs at the interpretations stage (Hanson et al., 2005). Research methods are combined in order to best capture the perspectives and values of underrepresented groups. The aspiration is that research will ultimately promote positive change and empower those studied; hence transformative paradigms have also been defined as "emancipatory" philosophical paradigms (Mertens, 2005). These designs are useful for giving voice to diverse or alternative perspectives, advocating for research participants, and better

understanding a phenomenon that may be changing as a result of being studied (Hanson et al., p. 229).

Several components of this study are aligned with the goals of transformative research designs. The population under investigation is often marginalized and oppressed. Children and adolescents do not have the same rights and privileges as adults. Inner-city youth are often further disenfranchised by poverty, crime, and ineffectual educational and public service systems. There is a disproportionate number of ethnic minorities among inner-city youth, who must struggle against additional racial inequalities. Several researchers suggest that it is these compounded forms of oppression and inequality which perpetuate community violence (Allen, 1996; Hill et al., 1996). The culture of violence therefore becomes an additional form of oppression for many youth. A cycle of aggression is perpetuated whereby the oppressed become the oppressors. In many ways, inner-city youth exposed to chronic community violence may be considered one of the most oppressed and powerless groups within American society.

In the spirit of transformative research, this study hopes to identify some of the myriad stressors experienced by the population under

investigation; as well as, discover areas of potential strength and growth which may be maximized. The primary goal of transformative mixed method designs is to utilize multiple methods to promote social change at levels ranging from the personal to political (Cresswell et al., 2002). This study hopes to promote social change in three different domains: the personal, the interpersonal, and at the organizational or community level.

Study Sample

The sample for this study consisted of twelve youth between the ages of twelve to eighteen who have been exposed to chronic community violence. Subjects were selected from two community-based programs. All of the subjects selected resided in neighborhoods where there was a prevalence of community violence. The study sample consisted of both male and female participants. The sample was heterogynous in regards to members' racial or ethnic group.

The rationale for selecting such a diverse study sample is to examine a broad, rather than limited, range of experiences and perspectives regarding community violence. Creswell (1998) employs similar strategies in his qualitative case study research. "I prefer to select

unusual cases in collective case studies and employ "maximum variation" as a strategy to represent diverse cases to fully display multiple perspectives about cases" (Creswell, 1998, p. 120). A comprehensive literature review of community violence suggests that there are myriad causes and consequences which may vary from child to child. Examining youth of different ages, gender, and ethnicity can yield interesting similarities or differences. Table 2 presents the demographics of the sample study, including self-identified race and ethnicity. By employing "maximum variation" in selecting the study sample, this study aims to examine the multitude of variables which interact with chronic exposure to community violence.

Table 2: Demographics of Sample Study

Subject	Gender	Age	Race/Ethnicity
Jordan	Male	12	African-American
Tamika	Female	14	African-American
Tonia	Female	15	Mixed Race
Yvonne	Female	16	African-American
Sarya	Female	16	Samoan
Paula	Female	15	Chinese American
David	Male	16	Haitian/Filipino
Cynthia	Female	17	Chinese
Trevon	Male	17	Filipino
Raheem	Male	18	Polynesian
James	Male	16	African-American
Miguel	Male	17	Latin American

Subjects were selected to participate in this study based upon the following criteria: (a) expressed interest to participate in the study by each participant; (b) prior experience to violence or related stressors; and, (c) parental cooperation and informed consent. Participants involved in a community-based program were referred by qualified staff. All participants were screened to assess the severity of their trauma and determine whether participation in the study could be potentially harmful. One of the instruments used in the study is commonly used to diagnose PTSD in children. For those participants whom there was evidence of current severe PTSD symptoms, a safety assessment was conducted. At the end of each interview, each participant was assessed for risk and offered referrals for additional mental health intervention. Therefore, integrated into the research procedure were several safety precautions to protect participants as well as identify those who may be in need of additional psychological intervention.

Procedures for Data Collection

The procedures for data collection involved two phases: initial referral and screening; and, assessment and structured interview sessions. The initial referral and screening phase insured that appropriate youth

were selected to be part for the study; and that all legal and ethical standards were adhered to prior to participation. Following the initial referral and screening phase twelve separate interviews were conducted with twelve participating youth. The interview phase included a combination of standardized assessment instruments as well as semi-structured interview protocols. Youth identified as moderate or high risk were referred for additional services and interventions (within the parameters of confidentiality).

During the initial referral and screening phase, the researcher and the staff at the community-based organization identified potential participants for the study. Once identified, youth were informed about the goals of the study and asked if they wish to participate. Those who express interest in participating were given a research participant packet. Each research participant packet included the following: parental and participant letters of informed consent, research project description, bills of rights for research participation (see Appendix A). Once the research packet documentation was returned, the project researcher contacted each potential participant and their guardians to confirm their participation, answer questions or concerns, and schedule times for interviews.

Each individual participated in a semi-structured interview which lasted approximately 1 1/2 to 2 hours. At the beginning of the interview, the study consent form was read and signed by each participant. Each participant was also informed that the interviews would be tape recorded. The first phase of the interview involved completion of two structured assessment instruments: *The Children's PTSD Inventory* (Saigh, 2004), and *The Survey of Exposure to Community Violence* (Richters & Martinez, 1998). The second phase of the interview was a semi-structured interview with the opportunity for open-ended questions and statements from participants. The description and psychometric properties of each instrument and interview protocol are described below.

Assessment Instruments: Measures & Procedures

Survey of Children's Exposure to Community Violence

The Survey of Children's Exposure to Community Violence (Richters & Martinez, 1998) was completed by the subjects participating in this study. This measure assesses the frequency with which a child has been victimized by, has witnessed, or has heard about 20 forms of violence and violence related activities in the community. The Survey of Children's Exposure to Community Violence was used to assess both

environmental factors as well as individual experiences related to community violence. The Survey of Children's Exposure to Community Violence provided critical data related to the types of violence in the communities where the participants lived. This instrument also yielded additional information about the frequency and types of violence which individual subjects have been exposed to.

Children's PTSD Inventory

The Children's PTSD Inventory (Saigh, 2004) was developed on the basis of DSM-IV criteria for PTSD. Empirical results indicate that this structured interview has very good reliability and validity (Saigh et al., 2000). Administration of the instrument takes 15-30 minutes to administer to children with trauma histories (and about 5 minutes for those with no trauma history). Examples of traumatic ("scary") experiences are described, and then the child is asked if he or she has ever experienced a scary event. If yes, the child is asked (a) if the event scared the child, (b) if the child felt upset when it happened, and/or (c) the child felt he or she could do nothing to stop it from happening. If answers indicate either a traumatic stressor did not occur or if the child did not react negatively to it even if it did happen, the interview is terminated, and the child is

diagnosed with no PTSD. If the interview is not terminated several additional yes/no questions are asked: 11 concerning re-experiencing symptoms, 16 concerning numbing and avoidance, and 7 concerning arousal. Questions related to duration of symptoms are also asked. The instrument yields the following diagnoses: Negative PTSD, Acute PTSD, Chronic PTSD, Delayed Onset PTSD, and No Diagnosis (i.e., insufficient information).

Semi-Structured Interview

An interview questionnaire developed by the researcher was used for the semi-structured interviews (see Appendix B). The semi-structured interview was used as an opportunity to gain additional information from participants which may not have been addressed by the assessment instruments. The interview also provided participants with the opportunity to freely express their own experiences and perspectives as they pertain to the topics under investigation.

At the end of each interview, the researcher brought closure to the session and assessed any areas of concern which may remain for the client. The researcher offered each individual the opportunity to be referred for additional services. Services offered ranged from contact

information to the staff clinician, program director or researcher, to referrals for on-going psychotherapy. These services were only offered as an optional support to participants, and they were explicitly informed that their participation in the study was not contingent upon complying with additional mental health services. Confidentiality was strictly maintained unless an individual elected to share their information with a referring clinician and signed a release of information for the purpose of informing treatment planning.

The integration of support services within this research project was consistent with the philosophical perspective of transformative research designs, as well as the ethical standards of clinical psychology. Transformative research aims at empowering disadvantaged populations from the individual to societal level. Rather than merely identifying the "risks" associated with community violence, this study intended to ameliorate those risks if possible.

Data Collection and Analysis

Lincoln and Guba (1985) recommend a case study structure which is most relevant to the research question under investigation. They divide case study research into four general areas: the problem, the context, the

issues, and the lessons learned. The recommended procedures for analysis of multiple cases typically involves a within-case analysis of case details and themes, followed by a thematic analysis across the cases, called a cross-case analysis (Creswell, 1998; Lincoln & Guba, 1985). Multiple sources of information are recommended when conducting a comprehensive case analysis (Creswell, 1998). The proposed study will involve the analysis and integration of different types of data for each case examined. Hanson et al. (2005) present the typical procedures for data collection and analysis in mixed-method approaches identified as concurrent transformative designs. They indicate that qualitative data and quantitative data are collected and analyzed at the same time. Data analysis is usually separate, and integration usually occurs at the data interpretation stage. Based upon these recommendations, the qualitative interview component of this study was analyzed separately from the quantitative data obtained from the standardized assessments. Integration of data was conducted according to multiple case study procedures (Creswell, 1998; Lincoln & Guba, 1985). Qualitative and quantitative data were compared as part of a within case analysis followed by an analysis across cases.

The semi-structured interviews were taped, transcribed, and analyzed to allow dominant themes or categories to emerge from the data. Once dominant categories were identified, transcripts were coded according to the established categories. Relevant material from the transcripts was arranged by the dominant categories into an individual case narrative. From this data reduction, material was then analyzed across the cases according to the dominant categories identified. Each dominant category yielded relevant themes based upon cross-cases comparison and analysis. These themes were then described and relevant qualitative data was presented. Qualitative data reduction and analyses were conducted according to the constant comparative approach described by Corbin and Strauss (1990). This process is described as a method of constant comparative analysis with data that is systematically gathered and analyzed (p. 273). As new information emerges during the process, theories may be generated from the data or elaborated on and modified.

The assessment and survey instruments were scored according to the procedures identified for each instrument. The quantitative data obtained from the assessments and surveys will be compiled to analyze

similarities and differences across cases. This data was presented to provide overall quantitative findings and trends in the data. A profile was developed for each participant based upon the quantitative results obtained from the assessment instruments. Data from the individual assessments was then integrated with the themes identified from the qualitative analysis of case transcripts. For each subject, individual case synopsis included the quantitative data from individual survey and assessment instruments as well as qualitative data from each interview. This data was then compiled and compared during cross-case analysis.

The data from the collective case study approach will be analyzed by methods described by Miles and Huberman (1994). This general approach to analysis is described as:

> Affixing key words, themes and sequences to a set of field notes drawn from observations or interviews to find the most characteristic account;
>
> Sorting and sifting through these materials to identify similar phrases, relationships between variables, patterns, themes, distinct differences between subgroups, and common sequences;
>
> Isolating these patterns, commonalities and differences, and taking them out to the field in the next wave of data collection; and,
>
> Gradually elaborating a small set of generalizations that cover the consistencies discerned in the database. (p. 87)

The utilization of a mixed-method research design may yield complimentary or discrepant results. Analysis will consider both the similarities in results as well as deviant findings which may reveal important anomalies. Patterns and relationships between variables will be isolated then reevaluated during follow up investigations. As a result of this continual process of testing patterns and commonalities, consistent findings should emerge which provide unique insight relative to the research question under investigation. In the final interpretive phase, the results are analyzed to report the “lessons learned” from the study (Lincoln & Guba, 1985).

The final stage of data analysis was conducted to discern overall patterns and distill emergent theories. This process involved analyzing the data from a process-oriented perspective rather than a content-based view. One of the advantages of qualitative studies is that they can potentially yield new theories during the process of data analysis and refinement. In the current study, certain processes gradually became evident. Based upon the individual and cross-case data, a hypothesis emerged which was compared against the overall data. The result was a

theoretical model for the developmental process of risk and resiliency as it pertains to chronic community violence.

CHAPTER FIVE: RESULTS

The results of this study have been divided into four separate sections. The first section addresses the quantitative results, consisting of summaries of the two standardized measures utilized: the *Exposure to Community Violence Survey* (Richters & Martinez, 1998), and the *Children's Posttraumatic Inventory* (Saigh, 2004). The second and third sections present qualitative data results. The first qualitative section includes selected individual case studies. The second qualitative section presents the data from cross-case analyses. The final section of the results involves an integrated analysis of the overall findings and presents a hypothetical theory for the developmental processes related to community violence.

Quantitative Results: Summary of Assessments & Surveys

The quantitative results consisted of data gathered from standardized survey and assessment instruments used to measure community violence exposure and PTSD diagnoses and symptoms. The sample size used for the current research study was not large enough to conduct accurate statistical analysis. Therefore, the quantitative data presented should be considered as illustrative and adjunctive to the qualitative data results. The quantitative data does however present an

informative glimpse of the overall prevalence of exposure to community violence as well as the resultant posttraumatic responses and symptoms.

Rates of Exposure to Community Violence

Results of the *Exposure to Community Violence Survey* (Richters & Martinez, 1998) indicate that the youth selected for the current study had relatively high levels of exposure to community violence. Table 3: *Rates of Exposure to Community Violence,* presents a summary of respondents' responses to questions on the survey.

The Exposure to Community Violence Survey (Richters & Martinez, 1998) consisted of a Likert scale in response to twelve questions pertaining to community violence. Subjects were asked to rate the frequency that they experienced each situation, from "never" to "many times."

Table 3: Rates of Exposure to Community Violence

Survey Question	Frequency (N=12)							
	Many Times		A Few Times		Once or Twice		Never	
I have heard guns being shot.	10	84%	1	8%	1	8%	0	
I have seen someone arrested.	9	75%	3	25%	0	0	0	
I have seen drug deals.	9	75%	3	25%	0	0	0	
I have seen someone being beaten up.	6	50%	3	25%	3	25%	0	
My house has been broken into.	0		1	8%	5	42%	6	50%
I have seen someone get stabbed.	1	8%	3	25%	2	17%	6	50%
I have seen someone get shot.	2	17	3	25%	2	17%	6	50%
I have seen a gun in my home.	2	17	2	17%	2	17%	6	50%

I have seen alcohol in my home.	5	42	3	25%	3	25%	1	8%
I have seen gangs in my neighborhood.	9	75	2	17%	1	8%	0	
I have seen someone pull a gun on another person.	3	25%	3	25%	3	25%	3	25%
I have seen someone in my home get shot or stabbed.	0		2	17%	2	17%	8	67%

The results indicate that the youths' most common experience related to community violence was hearing gun shots. All of the subjects had heard gun shots. Ten of the twelve youth (84%) indicated that they had heard gun shots "many times." There were three community violence related events which were experienced by all of the youth and rated as occurring "many times" by nine (75%) of the respondents. These three experiences were: witnessing arrests, witnessing drug deals, and seeing gangs in one's neighborhood. Thus, every one of the twelve youth

interviewed heard gun shots and witnessed arrests, drug deals, and gangs with frequencies ranging from occasional to many times.

There were other items on the community violence survey which were experienced less frequently, but which were potentially much more threatening and traumatizing. These violent acts included witnessing people shot, stabbed, or beaten up. An alarming 50% of the youth had witnessed someone getting shot and stabbed. Half of the youth had also seen a gun in their own home. Nine of the youth (75%) had seen someone pull a gun on someone else. Four of the twelve youth (33%) had witnessed someone get shot inside of their own home. These experiences of violence exposure were particularly severe and potentially damaging, and considering their severity, occurred in alarming frequency.

PTSD Diagnoses & Symptoms

A standardized assessment instrument, *The Children's Inventory of PTSD* (Saigh, 2004), was used to determine specific posttraumatic symptoms and derive PTSD diagnoses based upon the DSM-IV diagnostic criteria. The diagnostic tool included symptoms related to the three main symptom clusters identified as part of the diagnostic criteria: re-experiencing; avoidance and numbing; and increased arousal. The

instrument also assessed traumatic severity and the extent to which symptoms impacted functioning in various domains. Scoring of assessment results yielded four PTSD diagnoses: Negative PTSD; Acute PTSD; Delayed Onset PTSD; and, Chronic PTSD. Table 4 presents the diagnoses of each subject, as well as the number/percentage of symptoms endorsed in each of the three symptom cluster areas.

Quantitative analysis of the PTSD assessments results indicated that ten of the twelve subjects interviewed (84%) had diagnoses of PTSD. Of these ten, eight had diagnoses of Chronic PTSD, and two had diagnoses of Acute PTSD. This appeared to be a relatively high prevalence of PTSD considering the range of violence exposure and trauma experienced by the youth. Few of the youth had ever been diagnosed with PTSD, nor had they received professional treatment. The interview conducted was the first time many of them were assessed for PTSD, with an alarming 84% meeting DSM-IV diagnostic criteria.

Table 4: PTSD Diagnoses & Symptoms

Subject	Exp. Level	PTSD Diagnosis	Re – Experiencing		Avoidance & Numbing		Increased Arousal	
Jordan	I	Chronic	5/5	100%	3/7	43%	5/5	100%
Tamika	I	Negative	1/5	20%	3/7	43%	1/5	20%
Tonia	II	Chronic	5/5	100 %	4/7	57%	5/5	100%
Yvonne	II	Chronic	5/5	100%	6/7	86%	5/5	100%
Sarya	II	Acute	5/5	100%	7/7	100%	4/5	80%
Paula	II	Chronic	3/5	60%	6/7	86%	4/5	80%
David	III	Chronic	5/5	100%	7/7	100%	4/5	80%
Cynthia	III	Acute	4/5	80%	3/7	43%	3/5	60%
Trevon	IV	Chronic	5/5	100%	6/7	86%	3/5	60%
Raheem	IV	Chronic	5/5	100%	5/7	71%	4/5	80%
James	IV	Chronic	5/5	100%	3/7	43%	2/5	40%
Miguel	IV	Negative	4/5	80%	5/7	71%	1/5	20%
Total				*87%*		*69%*		*68%*

Analysis of the symptoms endorsed by each subject revealed the types of symptoms which were most prevalent among the subjects. Symptoms correlated with re-experiencing were the most common posttraumatic symptoms experienced by the youth. Re-experiencing symptoms were endorsed on average 87% of the time by the respondents, compared to avoidance/numbing symptoms and increased arousal, which were endorsed 69% and 68% respectively. These results suggest that youth exposed to community violence tend to predominantly exhibit re-experiencing symptoms in response to trauma.

Although the quantitative results of this study do not yield statistically significant empirical findings, these results do suggest that both community violence exposure and resulting posttraumatic stress disorder are disturbingly common amongst inner-city youth. Equally distressing is how frequently these problems go undiagnosed and untreated.

Qualitative Results: Individual Case Summaries

The first section of qualitative data presents the individual case summaries of select youth who were interviewed for this study. After reading through all of the interview transcripts and affixing codes to the data, main categories were identified which were present across all of the case studies. The raw data from each case study was then summarized and arranged based upon the eleven categories. The dominant categories identified were:

Environment

Critical Incidents

Relationship to Victim

Trauma Related Diagnoses and Symptoms

Dynamics of Violence

Risk Factors

Protective Factors

Resiliency

Making Meaning

Causes of Youth Violence

Recommendations

The cases were further divided into categories based upon levels of violence exposure. This was done to organize the cases in a systematic manner, and provide a basis for comparison between cases. Analysis of the interviews yielded four levels of violence exposure. The first level was termed "Vicarious Traumatization," and included youth who were not directly exposed to violence, but indirectly effected by it. The second exposure level was "Witnesses," and included those youth who directly witnessed an act of community violence. The third exposure level was "Direct Victims," and this consisted of individuals who had been victims of community violence and identified this event as their primary trauma. The fourth exposure level was termed "Victims and Perpetrators." This category was included because there were several youth who had been victims of violence, but who also admitted to committing a great deal of violent acts themselves. For each exposure level, two cases were selected which matched the criteria. This was done for purposes of providing of symmetry and to allow for in-depth presentations of select cases rather than superficial presentations of all twelve cases.

Exposure Level One: Vicarious Traumatization

Jordan

Environment

Jordan is a twelve-year-old African American boy. He lives with his mother and fourteen-year-old sister. The family lives in a neighborhood were there is an extremely high rate of crime and violence. In the neighborhood where they live, there are two competing gangs, or "sets" as referred to by youth in the neighborhood. Jordan's family lives on the border between these two warring gangs. Recently, his sixteen year-old- brother had to move out of the home because one of the gangs wanted to kill him. According to Jordan, his brother had been confused with another neighborhood youth who was involved in gang activity. As a result, his life was in serious danger. In order to remain safe, Jordan's older brother had to move in with relatives who lived in a city twenty miles away. Jordan's mother hoped to move the family to the same city in the near future and get away from their current neighborhood.

Jordan and his older sister, Tamika, both participated in interviews for this research project. They both described a great deal of violence and crime which existed in their neighborhood. They also reported some of the

same violent events which involved people close to them. However, what may be considered as objectively similar events and circumstances were subjectively experienced very differently. There were significant differences in the personal meaning attributed to traumatic events and the impact it had upon each child's posttraumatic response and subsequent development.

Based upon the *Exposure to Community Violence Survey* (Richters & Martinez, 1998), Jordan identified the frequency of different forms of violence that he has witnessed, rating them as follows: (a) Many Times; (b) A Few Times; (c) Once or Twice; and, (d) Never. Types of violence Jordan has been exposed to are summarized below in order of frequency, followed by descriptions of specific events which were most significant or severe.

The following incidents have been witnessed by Jordan *Many Times*:

I have heard guns being shot.
I have seen somebody arrested.
I have seen drug deals.
I have seen someone getting beaten up.

The following incidents have been witnessed by Jordan *Once or Twice*:

I have seen gangs in my neighborhood.

Critical Incidents

Jordan did not report being the direct victim of violence, yet he was traumatized by events which occurred to people close to him. Two cousins of his were shot; one died, and the other survived after critical surgery. Jordan did not witness the shootings; however, he was present with family members when they found out about them, or speaking to them on the telephone. He vividly described when he was talking over the cellular phone to his brother at the exact moment when his cousin was shot. Jordan also recalled the phone call his mother received after his other cousin was shot and killed. Jordan expressed significant fear and worry about his older brother, who was a potential target for gang violence. Despite not being a direct victim or witness, Jordan endorsed several trauma-related symptoms and met the criteria for Chronic PTSD according to the *Children's PTSD Inventory* (Saigh, 2004).

The most significant critical incident for Jordan seemed to be the shooting of his older cousin two years ago. The majority of PTSD-related

symptoms were related to this event and his relationship to the victim. Jordan recalled when his mother received the call on her cell phone. He said that “everybody in the car was crying.” His cousin died soon afterwards. This event was most troubling to Jordan because of the close relationship he had with his cousin.

Another cousin of Jordan’s was also shot, but lived. According to Jordan, his older brother was with his cousin when he was shot by other youths. His older brother fell to the ground and was crying through the phone while Jordan could hear his cousin yelling in the background. Jordan recalled his cousin’s voice through the phone, “He was saying, ‘Oh man! That hurt!’ He kept on screaming, ‘Oh!’.” As Jordan described the incident he pointed in the distance and said that it happened “right over there, like three blocks down.” Jordan said that his cousin was taken to the hospital to have surgery and lived. However, his cousin was shot in the head, and as Jordan described, “He can walk and everything but he can’t talk. He’s kind of retarded.”

The third critical incident identified by Jordan was when his brother was a target of gang retaliation. According to his explanation, his brother was mistaken for another person, whom a neighborhood gang

wanted to kill. Jordan described how scared he and his family were when he was being pursued by the other gang. Finally, his brother was able to move to another city with relatives, where he has stayed since. He is glad that his brother is safe now, but wishes that his family could be together.

Relationship to Victim/Victimization Experience

Jordan was very close to his cousin who was shot and killed. His relationship to his cousin appeared to impact the severity of grief-related and PTSD symptoms. When describing his cousin, Jordan said, "He took me to his house, he cooked for me, my cousin, he did everything for me." During the course of the interview, Jordan recalled several memories of special events and experiences with his cousin. Jordan's grief and loss related to his death were often triggered by events which reminded him of his cousin. An example of Jordan's associations to his cousin was when he was asked if there people, places, or things that reminded him about his cousin's shooting. He responded, "Spaghetti." When probed further how "spaghetti" reminded him of his cousin's death, Jordan answered, "'Cause he—when I went to his house, he cooked me spaghetti. He cooked me sumptuous spaghetti."

Trauma

Based upon the *Children's PTSD Inventory* (Saigh, 2004), Jordan has a diagnosis of Chronic Posttraumatic Stress Disorder. Although he did not directly experience a trauma to himself, he was traumatized by the vicarious experiences inflicted upon those close to him. These vicarious events included: the murder of his cousin, the shooting of his other cousin, and the fatal threat towards his brother. His reactions to these traumatizing situations are indicative of PTSD. He also endorsed the required number of symptoms in the four main domains related to PTSD: re-experiencing; avoidance and numbing; increased arousal; and, significant distress. The majority of symptoms persisted longer than three months after the incident(s), which meets the criteria for Chronic PTSD. Specific descriptions of symptoms he endorsed are listed below according to the respective symptomatic category.

In regards to exposure to trauma and situational reactivity, Jordan met the DSM-IV criteria for PTSD. Jordan indicated that his cousin being shot was a very scary event for him. Even though he was not physically present when it happened, he was on the phone with his brother who was present. Jordan answered affirmatively to all of the questions related to

situational reactivity. He was very scared and upset when the event occurred. He felt that he could do very little to prevent it. And he moved around or talked more than usual when the traumatic event happened. Jordan added, "I was mad…I got into a lot of trouble in school."

Based upon the PTSD symptom cluster related to re-experiencing, Jordan endorsed all of the symptom criteria. When asked whether he had upsetting thoughts about what happened, he described, "Like, I heard him on the ground saying, "Ahhh! Ahhh!" and then, and my brother…" When asked whether images or pictures pop into his head about the event, he responded, "Everyday." Jordan described nighttime fears related to the event when asked whether he had bad dreams about the event. He said that on his cousin's birthday two years ago, he was sleeping on his top bunk of his bunk bed and when he woke up he felt his arms and legs making out of control movements. Jordan added that he thought his cousin came as a ghost. Now he has bead dreams whenever he sleeps on the top bunk and refuses to sleep up there anymore.

Jordan has re-experiencing symptoms related to people, places and things that remind him of the event. When he hears about people being shot, he remembers his cousin. He also said that spaghetti reminds him of

his cousin, because he used to make that for him. Jordan is reminded of the shooting of his other cousin whenever he walks past his house. As he describes, “It was bullet holes in the walls but they covered them up. I could still see them though. I could still see the spots where they are.”

Jordan experienced physiological reactions in response to situations that reminded him of the events. He said that his heart beats faster, his palms become sweaty, and he has stomach aches. He also said that he his breath “becomes shaky.” Jordan said that he gets these sensations because he feels “like something’s going to happen.”

In regards to the avoidance and numbing symptom cluster, Jordan endorsed three out of the seven PTSD-related symptoms. He indicated that he tried to avoid thoughts and feelings related to what happened. He also avoided people and places that remind him of the events. Jordan also reported that his view of his own future changed after the traumatic experiences. Specifically, he was asked if he changed his mind about his chances of having a long life. His response was, “I don’t think I would have [a long life]. I think something would happen to me…Yeah. I am going to be shot or somebody going to stab me or I’m going to be in a coma or something.”

Jordan endorsed all of the PTSD-related symptoms in the increased arousal cluster. Jordan has trouble sleeping, especially when he hears gun shots. He endorsed all symptoms related to irritability and outbursts of anger, reporting that he easily gets angry, yells at people, and gets into fights. He also has trouble concentrating and paying attention during class. Jordan is more watchful and careful since the shootings of his cousins. He is also startled by sudden sounds. Jordan reported that most of the symptoms of increased arousal continue to bother him, years after the traumatic events. When asked if the symptoms happened before his cousins were shot or after, he stated, "Before and after and still."

Examination of the level of significant distress these symptoms caused yielded intriguing responses from Jordan. When asked how he has been feeling in response to these events he responded, "Upset and mad and miserable." Jordan said that he somehow feels like he "was the reason" for what happened to his brother and cousin. When asked for further explanation, he responded, "I don't know how to explain…I just feel that way."

Dynamics of Violence

Jordan also indicated that he has had significant problems with his behavior in school since the events that happened to his cousins and brother. He said that other kids keep messing with him, then he's "the person who gets in trouble." Sometimes he is able to tell the teacher, but other times he starts fighting with his teacher. According to Jordan these problems, and his grades, have gotten worse since the events that happened to his cousins and brother. Jordan also indicated that he is angrier and fights more often since the traumatic events occurred.

Risk Factors

There are environmental and individual factors which place Jordan at risk. Based upon his portrayal, Jordan's neighborhood is a source of constant re-traumatization. The constant sound of gunshots triggers a startle response, impacts his sleep, and keeps him hypervigilant. He is surrounded by reminders of the violence which took the lives of people close to him (e.g., bullet holes in buildings, gang members, etc.). Jordan's own posttraumatic symptoms also place him at risk for future involvement in violence. As he stated, his angrier and gets in more fights since his cousins were shot. Jordan is at risk for academic failure as a

result of his trauma-related symptoms. He reports that his grades have gown down significantly, and that he has trouble concentrating. Jordan is potentially at risk for childhood depression based upon some of the emotions and symptoms he described. He appears to be coping with relatively intense grief-related emotions. He also said the there are times he feels "mad, sad, and miserable."

Protective Factors

Jordan identified several sources of social support in his life which have helped him deal with his trauma and grief related difficulties. When asked how he got through such painful experiences, he first identified his mother, sister, and brother. He said that they talked to him. When asked how they help him deal with the violence in the neighborhood, Jordan said, "My Mom tells me that, don't think about it. It's none of our family…or nobody we know." Jordan also identified his grandmother and aunt as people in his extended family who have helped him.

Jordan identified the youth program as a community resource that has helped him deal with his difficulties. Specifically, Jordan named his teacher at the youth program as someone who helps him deal with difficult experiences. He said that he had friends at the program, and it

was someplace safe where he could come and play and engage in enrichment activities such as the “computer lab.” Jordan also named the youth program as a place that helps youth deal with violence in their neighborhood.

Resiliency

Jordan was able to identify his own ways that he coped with painful or scary feelings. Jordan appeared to use distraction as a means of coping with overwhelming emotions and fears. He said one way of dealing with difficult feelings and experiences was “Me doing things that I like to do…Like going to Chuck E. Cheese.” When asked how these fun places and things help him, Jordan responded, “Stops me from being sad and stuff.” Then he was asked how he helps himself when he feels scared or fears that he might get shot. Jordan responded, “I’d get under the covers and close the window, and close the blinds and turn up the TV and do all that stuff.”

Making Meaning

The violence Jordan is surrounded by, compounded by the deaths of people close to him, appear to have most affected his own hopefulness for the future. Twice he said that he worries that something bad will

happen to him. Jordan added, "'Cause like everybody don't like somebody. You got to have somebody to hate." He further explained that somebody might do "something really stupid." According to Jordan, the threats and shootings of his family members were mostly mistakes in which the wrong person was killed. Consequently, Jordan seemed to have a very unstable sense of safety and security; that no matter what you did, you could get shot and killed just because "somebody does something really stupid."

During the interview, Jordan was asked, if he could change anything that has happened in his life, what would he change. He responded that he wished all guns would be taken away and his family would hang with good people.

Beliefs about Community Violence

Jordan felt that the primary cause of violence among youth was because of territorial fights between different neighborhoods. He described how people from one neighborhood keep shooting people from another neighborhood. He described it as people doing bad stuff to other people, then someone gets revenge and the fighting continues.

Recommendations & Solutions

Jordan was asked what he thought could stop all the violence that was happening around him. He fantasized, "Like I could free everything with my mind. Just freeze everything and take away stuff…I'd take away like all the…guns and all bullets and all the knives."

Tamika

Environment

Tamika is a fourteen-year-old African American girl. She lives with her mother and twelve-year-old brother. Tamika and her younger brother, Jordan, both participated in interviews for this research project. They both described a great deal of violence and crime which existed in their neighborhood. They also reported some of the same violent events which involved people close to them. However, what may be considered as objectively similar events and circumstances were subjectively experienced very differently. There were significant differences in the personal meaning attributed to traumatic events and the impact such events had upon each child's posttraumatic response and subsequent development.

The family lives in a neighborhood were there is an extremely high rate of crime and violence. In the neighborhood where they live, there are two competing gangs, and Tamika's family lives on the border between these two warring factions. Recently, her sixteen year-old-brother had to move out of the home because one of the gangs wanted to kill him. This event appeared to cause Tamika a great deal of concern, and she was relieved that he able to move someplace safe.

Based upon the *Exposure to Community Violence Survey* (Richters & Martinez, 1998), Tamika identified the frequency of different forms of violence that he/she has witnessed, rating them as follows: (a) Many Times; (b) A Few Times; (c) Once or Twice; and, (d) Never. Types of violence Tamika has been exposed to are summarized below in order of frequency, followed by descriptions of specific events which were most significant or severe.

Critical Incidents

The most critical incident identified by Tamika was her fear that her brother might get shot. Tamika did not identify being a victim to any direct form of violence or threat; nor did she witness violence committed against another person. Tamika did state that she was upset by the

shooting of her two cousins; one of whom died, and the other whom, suffered permanent brain damage. However, she did not initially identify these events as "scary" or traumatic experiences that she has had or witnessed.

Relationship to Victim

Tamika's close relationship to her brother intensified her concern when his life was potentially being threatened. When her cousin was shot she became worried that her brother would get shot also. Tamika expressed relief that her brother is now safe. She said that once he moved away, her feelings of being scared and sad went away.

Tamika said that her family plans to move to where he is currently living once school is over. Tamika agreed that her family will have to move to another city in order to keep her brother safe. She was asked if she was going to miss the people in her neighborhood when she leaves. Tamika's response was, "I'll be glad to get out of here."

The death of her cousin continues to have a lasting affect on Tamika. She was asked, if she could change anything that has happened in her life, what would she change? Tamika responded, "My cousin. I really loved him a lot."

Trauma

Based upon the *Children's PTSD Inventory* (Saigh, 2004), Tamika did not have a diagnosis of Posttraumatic Stress Disorder. She did not meet the full criteria for Posttraumatic Stress Disorder, based upon the diagnostic criteria established in the assessment instrument. Tamika met diagnostic criteria in some of the symptom clusters of PTSD, but not all four. She did not meet the diagnostic criteria in the PTSD symptom cluster of *Increased Arousal*; nor, did the symptoms she identified meet the diagnostic criteria for *Significant Distress.* However, Tamika did endorse a considerable number of symptoms in the following symptom clusters: *Situational Reactivity;* and, *Avoidance and numbing.* Specific descriptions of symptoms she endorsed are listed below according to the respective symptomatic category.

Tamika endorsed three out of the four symptoms related to *Situational Reactivity*. She identified with feeling scared and upset when her brother was threatened, and when her cousins were shot. She also felt that she could not do anything to stop the events from occurring.

Tamika only endorsed one of the PTSD symptoms related to the *Re-experiencing* cluster. She said that she becomes upset when she sees or thinks about people, places, or things that remind her of the incidents.

Tamika endorsed three of seven symptom areas related to the symptom cluster, *Avoidance and Numbing.* She avoids thoughts and feelings about what happened. She also avoids talking about what happened. She has tried to stop doing things that remind her of the events; as well as, staying away from people and places that remind her about what happened. She admitted to having difficulty remembering certain aspects about the traumatic events. An example was that Tamika could not remember exactly when her cousin was shot.

Tamika endorsed one symptom of the *Increased Arousal* symptom cluster. She said that she has become more careful and watchful since the events occurred. Tamika added that she does not say, “Hi,” to certain people whom she associates with the shootings and threats to her brother.

Tamika described reactions to the events that occurred which suggested that she may have experienced symptoms other than those typically associated with PTSD. When she hears gun shots, Tamika described feeling “sad” rather than “scared.” When asked about having

difficulty sleeping, Tamika said that she sleeps a lot. She also described trying to block out her thoughts and feelings related to the events; as well as her avoidance of talking to others about the events. Tamika's responses, as well as her affect during the interview, suggest that she may have experienced depression in response to her trauma rather than typical posttraumatic reactions.

Dynamics of Violence

Tamika described herself as being able to take care of herself; in other words, she was not physically intimidated by other youth. She stated that she occasionally got into fights, but not very often. She did not exhibit symptoms of hypervigilance, but rather appeared confident that other youth would not hurt or threaten her.

Risk Factors

The most prominent risk factor in Tamika's life was the environment she lived in where there was constant threat of violence. She had experienced a high level of indirect exposure to community violence, such as hearing gun shots, and witnessing gangs. These environmental threats placed her at risk of additional exposure to community violence.

Protective Factors

Tamika identified her mother as her primary source of support for helping her to cope with the trauma and violence she has experienced. She also identified the community-based youth program as a safe place where she could go. Aspects of the program that helped her feel better were that her mother worked there, and her friends were there. She said that the program is a place that "feels safe."

Resiliency

Tamika said that the reason she feels she is going to be okay, is, "'cause I'm confident." She explained what confidence meant to her. Confidence meant that she could take care of herself and "somebody won't touch me." She also said that she feels confident at school, because she gets good grades and gets along well with the teachers and other students. The personal aspirations which Tamika holds were not negatively impacted by her traumatic experiences. She said that when she wants to grow up, she still wants to be a lawyer, a celebrity lawyer.

Making Meaning

The traumatic events which happened to members of Tamika's family caused a change in her perspective. Before her brother was

threatened, and her cousins were shot, Tamika said she was not worried about her family. Now she says she is, “Worried more about my friends and family.” Tamika said that prior to those events she did not view her family as such a primary part of her life. But now she says that, number one is her and her family.

Beliefs about Community Violence

Tamika did not have any insight into the causes of violence in her neighborhood. She was asked whether she thought most of the people who are violent are other kids. Her response was, no, they are adults.

Recommendations & Solutions

Tamika did not provide any general recommendations for ending violence. Her personal solution was to that she was looking forward to moving so she could end this violence in her own life.

Exposure Level Two: Witnesses of Community Violence

Tonia

Environment

Tonia is a sixteen year old girl of mixed race. She lives with her mother, father, two sisters and one brother. Tonia and her family live in a neighborhood where there is a very high rate of violence and crime. A

large percentage of the violence is due to conflict between two neighborhoods in very close proximity of each other. On the *Exposure to Community Violence Survey* (Richters & Martinez, 1998), Tonia identified various forms of community violence which she has been exposed to. She identified the frequency of different forms of violence that she has witnessed, rating as follows: (a) Many Times; (b) A Few Times; (c) Once or Twice; and, (d) Never. Select types of violence she has been exposed to are summarized below.

The following incidents have been witnessed by Tonia *Many Times:*

I have heard guns being shot.
I have seen gangs in my neighborhood.

The following incidents have been witnessed by Tonia *A Few Times*:

I have seen someone get shot.
I have seen someone pull a gun on another person.
I have seen someone beaten up.

There were specific incidents of community violence that were particularly upsetting to Tonia. She witnessed one of her friends get "jumped." She felt that there was nothing she and her friends could do because they were outnumbered "like thirty to one." Tonia's friend who was jumped had to be hospitalized for at least 3-4 months. The most violent event described by Tonia involved witnessing the shooting of her

friend, who eventually died as a result. She identified this as the most traumatizing or "scary" event in her life; therefore, it is described in more detail under the category of *Critical Incidents*.

Critical Incidents

Tonia described a profoundly traumatizing event which occurred outside her school when she was fourteen years old.

> November 6th, 2003. We were just getting out of school. There was a fight on the back of the 29 [bus] and one of my friends got shot and he was pushing people out of the way, trying to break up the fight. When he was doing this, he happened to catch the bullet. And the scary thing was I felt his bullet go past my ear.

Later in the interview, Tonia described her understanding of the circumstances which led to the shooting:

> I think that was over some girl…Like his girlfriend was talking to this other dude and like they just started fighting. And then, the boy just started jumping him and then I guess he felt he had no way out so, he pulled out a gun and shoots. And he missed his target and then [hit my friend].

Relationship to Victim/Victimization Experience

Tonia was friends with the victim; and as a result, she experienced grief and loss combined with posttraumatic symptoms, after the shooting. Initially, she said she tried not to talk about what happened, and tried to seclude herself from others. She tried to block out her feelings according

to her. Teachers and friends at school tried to speak with her about what happened and she tried to avoid talking about the incident. She described her reaction as, "Like at first, I was like leave me alone, I don't want to talk about. Like how many times I got to tell you. I would just get irritated with it." Tonia didn't speak to anyone for several weeks. Over time however, she was able to share some of her feelings related to the loss of her friend. She describes how her feelings gradually returned, "Like a few months after, like I thought I didn't have no feelings and now I feel like I could just think about it, talk about it."

Feelings of grief and loss were very strong for Tonia although they took longer to "kind of sink in" according to her. She described how she was walking down the hall at school and someone had the victim's face on his T-shirt and Tonia started crying, adding, "It really just hit me that he was gone." She clarified that her emotional state was not sad or depressed, "It was just like reality…the reality that he's gone."

Tonia summarized the lasting impact of witnessing her friend's sudden death:

> Something like that ain't ever going to leave you. You won't remember the date but you would that day. How it happened, what you were doing that day…Cause it's something that's part of you. It's that part that is really close to you."

Trauma

Based upon the symptoms which Tonia has experienced since the incident, Tonia has a diagnosis of Posttraumatic Stress Disorder – Chronic Type. Tonia experienced certain PTSD symptoms more intensely than others following the incident. The most pronounced symptoms she initially experienced were part of the re-experiencing and numbing/avoidant phenomena characteristic of PTSD. Her initial response to the event relates to the PTSD category of Numbing and Avoidance symptoms. Immediately after the event she "secluded [herself] from everybody else." For three weeks immediately after the shooting, Tonia "didn't say not one word to anybody." She tried to avoid thinking about what happened and blocking out her feelings. "I tried to run away from it and hide from it but I couldn't." Initially she avoided places and people that reminded her of the shooting; and, she refused to ride the same bus anymore.

Tonia described pervasive re-experiencing symptoms immediately following the incident. "There was nothing else I could think about for a while." She had nightmares related to the shooting. She also had the feeling that the whole thing was happening all over again. She continues

to become upset when she sees people places or things that reminded her of the event. Two years since the event, Tonia says that she still remembers it very clearly, "Like it happened like this morning."

Tonia described several symptoms of hyperarousal, some of which continue to bother her. Her hands shake when she sees or thinks about people, places, or things that remind her of the traumatic event. Tonia's heart also beats rapidly when she is in situations that remind her of the shooting. After the shooting, Tonia also became very hypervigilant, to the point that she described herself as kind of "paranoid." She looked over her shoulder constantly. Sudden loud noises would also startle her and make her jump.

Tonia appeared to feel some guilt about the event. When asked weather she felt that she couldn't do anything to stop it from happening, Tonia responded, "I felt like I could have…Probably could have because I was on the bus when the fight just started and I could have done something but I didn't."

Tonia most likely also experienced some clinical depression after the incident, based upon the symptoms she described. When asked during the interview if she had trouble sleeping after the incident, Tonia

responded: "For a while, I would just like stay up for like extra hours. Then after that little period all I could do was sleep…after that four months all I could do was sleep. I was like dozing off just thinking about it." She also avoided many of the people and activities which she previously enjoyed. She isolated, was irritable, and had difficulty concentrating. All of these symptoms are indicative of a depressive episode.

Over the two years since the incident, many of Tonia's trauma and grief related symptoms have subsided. She is able to speak more openly about the incident and her feelings afterward. She does not experience such over-whelming re-experiencing symptoms such as nightmares or vivid images of the event "popping into her head." She also is not as avoidant of people and places that remind her of the event. Her range of affect is no longer as constricted. She described having "no feelings" immediately after the event. Now Tonia feels the range of her feelings coming back: "It's like you going to get mad about something, some things will make you sad, some things will make you happy."

Dynamics of Violence

According to Tonia, she became more aggressive following the shooting of her friend. “My temper has always been there, but after that like anything, any little thing would set me off.” She said that rather than yell at people, she would “just kind of snarl.” However, Tonia indicated that the shooting of her friend had changed her attitude about fighting. When asked if she got into more fights after the event she responded, “No, just after it happened, I told myself that I wasn’t going to get into anymore fights cause that happened cause of one fight.”

Risk Factors

During the course of Tonia’s interview, she eluded to behaviors or environmental factors which could potentially place her at risk for future exposure to violence or other detrimental outcomes. She indicated that she lives in a very violent and impoverished neighborhood. She also indicated that she has difficulty controlling her temper, although that has improved according to her. She also said that her grades have suffered, especially following the shooting she witnessed. Tonia felt unmotivated by the education she was receiving and that it had little relevance to her life. As

she stated, “They just re-teaching us stuff we learned in seventh and eighth grade.”

Protective Factors

Tonia clearly identified three ways that she got through her painful experiences: friends, family and writing. The most significant sources of social support for Tonia were her family and friends. She also indicated that teachers were helpful immediately after the shooting occurred. Friends helped Tonia cope with the loss of her friend. She said that after avoiding people for some time, her friends were eventually able to help her talk about her feelings. They also helped share the loss with her. Tonia indicated that her family was understanding about what happened. She described how her family said they are always there for her if she ever needed anything.

Tonia identified the violence prevention program as a major source of support for her. The program helped her to cope with her feelings related to the shooting and other forms of violence; and, it also provided her with a positive, proactive social outlet. Later in the interview she identified the program as one of the possible solutions to the violence problem among youth. When asked how the program helps her, Tonia

said that it helps her meet kids from her school and neighborhood she never knew before. She affectionately described the closeness she felt towards the staff and students who were part of the program:

> It's like, the people at UP is like a family, like everybody calls each other cousin, brother, sister, aunty, uncle, you're just like extended family. Like you support each other in whatever you're trying to do.

Resiliency

Writing was the most important coping mechanism Tonia identified for dealing with her personal, internal feelings. Tonia describes writing as the way she let her feelings out when she could not share them with anyone else:

> Like when my friends didn't get me, my family didn't get me, I just wrote like about what happened and how I was feeling at the time about it…For a while, like that's the only way I could let my feelings out about the whole situation. It's like for a while, a little like three weeks, I didn't say not one word to anybody.

Making Meaning

Over time, Tonia was able to attribute personal meaning to the tragic event. During the interview, Tonia was asked if she could change some of the things that happened, what would she change. Her response was, "I wouldn't have changed anything that happened because

everything happens for a reason…So, if he was going to be taken at that time, there's nothing I can do about it."

Tonia went on to explicitly describe how witnessing her friend get killed changed her attitude and perspective of the future. She claimed that "after that happened, it's like I kind of grew up." She described how the traumatic event she witnessed dramatically changed her attitude about violence and fighting:

> Yeah, I mean like, for me like if you got to shoot somebody, you weren't man enough to handle it with words or your fist. That's just like, after that happened, that's like really how I started thinking. Before that, I was like…kick him in his knee or something and then like knock him over. After that I was like, why can't you just talk about it. Like it's stupid to be fighting.

Beliefs about Community Violence

Tonia shared her beliefs related to the causes of violence among youth. She believed that violence was a result of kids her age feeling that they "got no way out."

> Cause a lot of the people that I know, they all live in projects or poverty and they felt like they ain't got no way out. Like they are probably upset about, confused, like I can't speak for everybody, but I feel like that's how they're feeling. And they like don't know how to release it…They feel like everybody trying to bring them down and they ain't got no one helping. Like nobody trying to help them up. Seems like everybody just trying to bring them down.

Recommendations & Solutions

When asked what could get rid of violence, Tonia stated that she did not think that was ever completely possible. Tonia articulated several recommendations for helping youth reduce the level of violence. Tonia felt that inner-city youth not having meaningful things to do and healthy ways to deal with their anger was a major contributor to youth violence. She recommended more programs for youth; especially one's related to physical health. As she iterated, "Some kind of sport or boxing program that they can get their anger out." Tonia shared conversations she has had with "problematic kids" and friends in which they say, "Man, we wish we had this, we wish we had that." Other enrichment programs for youth that she and other youth identified as meaningful included: professional art classes, dance classes, cooking classes.

Tonia emphasized how the violence prevention program she has been part of has been instrumental in dealing with youth violence. The program traveled and met youth from other violence prevention programs in New York City and other parts of the country. She described how impressed other visiting youth were about the program they had built up over ten years. She was proud of the accomplishments of the

violence prevention program she was involved in. As she emphasized, "Like somebody took ten years to get it this big. And it's just going to keep growing." When asked if she felt that violence was controlling the lives of youth in the group, Tonia responded, "No, cause I mean it's like there's just so many of us, I feel like we just stop fighting. To a point where it's just like barely any cause for violence."

Yvonne

Environment

Yvonne is a fifteen year old African-American girl. She lives with her twin brother and her mother. Yvonne and her family live in a neighborhood where there is a very high rate of violence and crime. A large percentage of the violence is due to conflict between two neighborhoods in very close proximity of each other.

Based upon the *Exposure to Community Violence Survey* (Richters & Martinez, 1998), Yvonne identified the frequency of different forms of violence that he/she has witnessed, rating them as follows: a) Many Times; b) A Few Times; c) Once or Twice; and, d) Never. Types of violence and or risk factors for potential violence Yvonne has been exposed to are

summarized below in order of frequency, followed by descriptions of specific events which were most significant or severe.

Yvonne endorsed the following statements as occurring *Many Times*:

I have heard guns being shot
I have seen somebody arrested
I have seen drug deals
I have seen gangs in my neighborhood

Yvonne endorsed the following statements as occurring *A Few Times*:

I have seen someone getting beaten up
I have seen someone get shot
I have seen alcohol in my home
I have seen somebody pull a gun on another person

Yvonne endorsed the following statements as occurring *Once or Twice*:

I have had my house broken into

Yvonne indicated that she has been exposed to a considerable amount of violence in her community. A week prior to the interview she had witnessed someone getting robbed in front of her. The event occurred in a downtown shopping area and the person was robbed for their portable MP3 player (iPod). Yvonne identified one event which was

particularly disturbing to her that occurred when she was Eight-years-old, described below.

Critical Incidents

Yvonne described one critical incident of community violence which she witnessed at the age of eight. According to Yvonne the event had a lasting effect upon her life and social functioning for many years after. She described the event as follows:

> I've seen when I was eight – I've seen somebody get shot in the – dead smack in the middle of their head outside in the middle of the street and his brains just rolled down the hill.

Yvonne described how this critical incident made her more aware of the violence surrounding her. She explained, "More people started dying like and I understand everything better because after I seen that I just started paying attention to everything more."

There have been many people who Yvonne has known who died as a result of community violence. Although she was not a direct victim, or witness, to the violence, some of these deaths have had a profound impact upon her. She described the deaths of two close relatives:

> My god-brother was killed two months ago. He was killed in the back of his house…and my cousin was there. It was a Police chase that happened and the Police chased him in his truck and his truck

> is shot up over some—my Auntie she investigated and everything, but like the two main people that I was close to that died.

Yvonne elaborated that her god-brother had just turned 21 before he was killed in the back of his house, and her cousin died two years ago.

Relationship to Victim/Victimization Experience

Yvonne said that her god-brother and cousin were the two people whom she was closest to that died as a result of community violence. She said that she still thinks about them a lot. When asked what she thinks about when she remembers them, Yvonne said, "I might sit there and want to know why but most of the time when I think about it I just sit down and write it to myself and that helps me express myself better…it helps me calm down…to just write to myself."

Yvonne did not report having any relationship to man who she witnessed get shot in the head when she was Eight-years-old.

Trauma

Based upon the *Children's PTSD Inventory* (Saigh, 2004), Yvonne has a diagnosis of Posttraumatic Stress Disorder of the Chronic Type. She described a witnessing an event which was traumatizing and her reactions were indicative of PTSD. She endorsed the required number of symptoms in the four main domains related to PTSD: re-experiencing; avoidance and

numbing; increased arousal; and, significant distress. The majority of symptoms persisted longer than three months after the incident(s), which meets the criteria for Chronic PTSD. However, Yvonne did indicate that several symptoms dissipated after two months, which suggests more acute PTSD. Other symptoms have persisted for years and some remain today. Specific descriptions of symptoms she endorsed are listed below according to the respective symptomatic category.

Yvonne endorsed three of the four symptoms related to situational reactivity. She was very scared after witnessing the man shot in front of her window. When asked if she was upset, Yvonne said she felt like she was in shock. She felt there was nothing she could do to prevent the event. Yvonne was asked whether she had symptoms of increased activity such as talking or moving around. She said, "No, I was just quiet is all."

Yvonne endorsed all of the symptoms of the *Re-experiencing* symptom cluster for PTSD. In regards to recurring thoughts or images of the event, Yvonne said when she went to sleep she would dream about the event. She also said that images of the event would pop into her mind. However, after two months, these images just stopped; Yvonne elaborated, "Like I just forgot about it." Yvonne had re-experiencing

symptoms like the event was happening all over again. Even now, eight years later, whenever Yvonne hears shooting, she feels like it just happened all over again. People, places and things that reminded her of the event upset Yvonne for several months after it occurred, but bother her less now. Yvonne endorsed all of the physiological reactions related to re-experiencing the trauma. Reminders of the event cause Yvonne to experience sweaty palms, increased heart rate, and stomach aches. She also felt dizzy, which was an additional symptom. Many of these symptoms persisted for about two months after the event.

Yvonne endorsed six out of seven of the symptoms related to the *Avoidance and Numbing* symptom cluster of PTSD. She tried to avoid thoughts and feelings related to the event. She also did not talk about what happened. She avoided people and places that reminded her of the event. Yvonne identified having difficulty remembering specific parts of the traumatic event. She elaborated, "Yeah, like well I still don't remember where the dude came from." Initially, Yvonne was more avoidant of others than she is today. She did not endorse feeling different than her classmates, nor did she feel uninvolved with other youth.

Several symptoms of avoidance and isolation were relatively extreme and persisted for several years according to Yvonne. As she stated, "It took me a good two years to start coming outside anymore…Like because I come outside now but not really because when all that happened I used to never come outside no more."

Since the traumatic event, Yvonne's perspective of her own future remained the same in some areas and changed in others. She has not changed her mind about what she wants to do in the future, or plans to get married or become a parent. However, she has changed her mind about her chances of having a long life. She explained, "Because it seems like now all teenagers don't live past the age of 18 and they're lucky is they live to be 21. It's like everybody is dying young. She added that it is "mostly boys." Yvonne's perspective was more related to deaths of other youth in her neighborhood than to the shooting she witnessed as a child. "Just in my neighborhood…I think over 12 people have died in the last three years.

Yvonne endorsed all of the symptoms related to the *Increased Arousal* symptom cluster of PTSD. She experienced difficulty sleeping and concentrating. She became angry easily, yelled often, and got into fights.

Yvonne indicated that she was very watchful and hypervigilant. She continues to have an exaggerated startle response to loud noises.

The posttraumatic symptoms described by Yvonne caused significant distress in different areas of her life. One of the areas most affected was her own capacity to regulate her emotions. Yvonne described her own hypersensitivity as follows:

> Because the littlest things…like can wake me up and somebody can just bang on the door and just because I'm already mad, I'm going to react like and then I'm going to act out like and it makes me even madder 'cause I'm already thinking about other stuff that may happen but the littlest thing it used to make me mad and just set me off.

Yvonne also described having some academic difficulties. Specifically, she had trouble concentrating, especially following upsetting events. She also described having considerable anxiety related to passing her exams required to graduate.

Other domains of Yvonne's life were not as significantly impacted by her symptoms. After her traumatizing experiences, Yvonne did not experience increased problems with her teachers, peers, nor family. She said that her family and friends have been very supportive.

Dynamics of Violence

Yvonne described how relationships to others affect her own aggression. She said that she becomes irritated when people “play too much.” Specifically, she seemed to become angry when other youth joke about serious and painful events like the deaths or shootings of other youth. She described her own reaction as follows:

> Like they just make little comments and maybe joke around like they keep talking about it and I don’t like when people keep talking about stuff that happened back to people that I was close to because it makes me keep thinking about it.

Once she reaches a threshold of annoyance Yvonne describes being “mad at everybody.” Yvonne continues to have difficulty with her temper, but she does not allow it to lead to physical fights. She shared her insight into her own sensitivity and hostility:

> Like the little stuff irritates me, so like if somebody do something—somebody bumps into me I’ll make it bigger than what needs to be…Sometimes I’ll fight, sometimes I won’t. Like I’ll argue with people or I might cuss you out. But it all depends like on how my day is.

Her anger also appears to be connected to the relationships she has to other victims. When other youth joke about victims of violence who Yvonne knows, her own grief and trauma reactions are triggered. As she describes it, she appears to be affected by the callousness of others; by

their lack of respect for the suffering of others, including Yvonne's own feelings of grief and trauma.

Risk Factors

Yvonne's social and physical environments are the primary risk factors in her life. She has known over ten young people killed in the past three years; people how physically lived in her neighborhood, as well as members of her extended family. Her sensitivity and anger appear to be trauma-related reactions to the chronic violence surrounding her. As a result, her symptoms are exacerbated by the constant reminders from her social environment, such as insensitive students at her school. Thus, her physical environment places her at risk for repeated exposure or victimization; and her social environment is a persistent trigger for her posttraumatic symptoms.

In contrast, Yvonne described a level of desensitization that she has developed due to her chronic exposure to violence. As she stated, "I'm used to that now; like, it don't even bother me anymore." She said that thoughts of people close to her who have died do come back into her mind, but even in relation to those losses, Yvonne elaborated, "I'm kind of

used to that now ‘cause it happened like a little while ago…so I’m used to that.”

Protective Factors

The sources of social support which Yvonne identified ranged from friends and family, to her part-time job, and her involvement in the school based violence prevention program. Yvonne said that her family has been a source of support for her, and she has been able to share her feelings with her mother.

The school-based violence prevention program has been instrumental in Yvonne’s capacity to cope with violence and find healthier alternatives for her. Yvonne described how the program director has been a role model for her:

> Like Rudy showed us these old pictures of all like this stuff he went through and like I just hope it like helps me more; like he’s changed as a person, so that means it is a chance for everybody to change; they just really got to want it.

The program has provided Yvonne with opportunities to go to different places and to “see stuff that we ain’t never seen before.”

Work has also been a source of positive support for Yvonne. She described the positive influence of work as follows, “Instead of being at work, I could be outside hanging out and everything else, but there I do

something productive." Yvonne also said that work allows her to learn from other people.

Resiliency

Yvonne identified writing as one of her most meaningful methods of coping with feelings related to the death and violence she has been exposed to: "Like instead of acting out in a violent way and fighting like I'd rather just write it down." She went on to explain what she writes about: "Like what happened, like what made me mad…I can be like 'oh here's what happened or like this one made me mad, like this one ticked me off—the littlest stuff." She summarized how writing has helped her cope with a range of emotions and situations: "I think writing has just helped me a lot like for all my situations—good and bad."

Making Meaning

Yvonne appeared to use fate as a way of making meaning out of the death and violence she was regularly exposed to. Due to the violence and loss surrounding her, Yvonne seemed to value her life more. She appeared to have a belief that anybody could die at any time; therefore, it was important to make the most of the life you have. In response to the recent death of her cousin, she attempted to describe this world view:

> [He died] like a few months ago…but like it happened—I already know it's a time for everybody to go so like…I trip on it still…I think about it to myself and write something down about it, but really I don't say nothing to nobody else about it.

The violence which Yvonne has witnessed and been surrounded by has changed her perspective and aspirations for herself. During the interview, she was asked how her exposure to violence (e.g., witnessing a murder as a child, or knowing many people who have been killed) has changed her view of life for herself. Yvonne responded, "Like it's not that much time, so instead of tripping on all the little stuff and arguing with people like do what I need to do to better myself and get away from all this…so I can be a better person on my own…It helps me to better myself in the end." She went on to explain how her exposure to violence has helped her to have a better perspective on her own life and future.

> I'm happy I seen some of the stuff that I've seen and some of the stuff that happened 'cause it made me think like it's not just a small world and things do happen like and it…made me better myself as a person; like I see stuff that goes on around me and I don't want to be involved with that, so I try my best to stay away from like all the messy stuff, the drama and everything else and the gangs and everything else and just do what I need to do to get out of here.

Beliefs about Community Violence

Yvonne viewed the cause of youth violence to be the multitudes of "problems" teenagers have these days and their resultant negative self-

concept. She said that teenagers have so many problems and violence is just their way of expressing themselves, "even though it's not smart or right but that's just their way of expressing things." She went on to explain the different types of problems she feels youth have to cope with. These included problems at home and "people outside that don't like them." She also identified school-related problems youth face, including poor grades, tests, teachers that don't like them, and conflicts with other students. Yvonne explained that kids get violent because they are brought down, feel bad about themselves, and "so they bring other people down with them."

Yvonne viewed access to weapons as a part of problem of youth violence, but not the primary cause. She said that there are too many weapons, beyond just guns, and that people fight, stab, and hurt each other in many ways. But the underlying cause of violence, as Yvonne conceived of it, was the negative self-concept youth had of themselves. Yvonne summarized her perspective: "Basically like they're depressed and they stressed out on their own self so they taking it out on everybody else that's around them."

Recommendations & Solutions

Yvonne did not feel that there was a "solution" for youth violence, but she did present specific recommendations for addressing the problem. The main recommendation she had was that there be more programs like the violence prevention program she was part of. She affirmed, "…like everybody needs a program that they can go to 'cause this program—everybody can be like they'll be doing something to better their self and learning at the same time." Yvonne described specific aspects of the program that she felt were most effective and helpful. The violence prevention program takes members to other parts of the city, and other parts of "the world." The program director also takes people to the jails "so they can see how the people in there live." Yvonne explained how discussion groups with youth members are also very helpful: "they sit down and talk about stuff that happened every day or whatever and like what affects them or whatever and I think that helps when people just sit down and talk about it."

Exposure Level Three: Direct Victims of Violence

David

Environment & Demographics

David is a sixteen year old Haitian boy who was born in the Philippines. He came to the United States when he was fourteen years old. He lives with his mother, father, grandmother and two siblings. David has seven other siblings who continue to live in the Philippines. David has been exposed to violence in his native country the Philippines; and, since arriving to the United States. The neighborhood where he currently lives has a high rate of crime and youth violence.

As a relatively recent immigrant to the United States, David had limited English proficiency. Therefore, he enlisted the help of a friend to translate when he had difficulty understanding a question, or had difficulty expressing himself. However, David was encouraged to answer questions as best as possible in his own words.

Based upon the *Exposure to Community Violence Survey* (Richters & Martinez, 1998), David identified the frequency of different forms of violence that he has witnessed, rating them as follows: (a) Many Times; (b) A Few Times; (c) Once or Twice; and, (d) Never. Types of violence

David has been exposed to are summarized below in order of frequency, followed by descriptions of specific events which were most significant or severe.

David endorsed the following items as having happened *Many Times*:

I have heard guns shot (Philippines and U.S.)
I have seen someone arrested (Philippines and U.S.)
I have seen someone beaten up (Philippines and U.S.)
I have seen someone get stabbed (Philippines and U.S.)
I have seen someone shot (U.S. more than Philippines)
I have seen alcohol in my home.
I have seen a gun in my home.

David endorsed the following items as having occurred *A Few Times:*

I have seen drug deals.
I have seen someone pull a gun on someone else.

David endorsed the following items as having happened *Once or Twice:*

I have had my house broken into (Philippines).
I have seen someone shot or stabbed in my home (Philippines).

Critical Incidents

David identified several traumatizing incidents which occurred both in the Philippines and in the United States. Some involved violence

while other traumatizing events were natural disasters that occurred while he lived in the Philippines. David and his family survived a landslide and an earthquake which happened while they lived in the Philippines. Regarding personal violence, David has been a both a direct victim and witness to several acts of violence in the Philippines and the United States. David described having a knife pointed at his face by another youth. He also described almost being shot during a "drive by." Both of these events occurred within the past year while living in his current neighborhood.

David has witnessed violence committed against people close to him on several occasions. When David was nine years old, he witnessed his seventeen-year-old brother get stabbed. According to David, he and his brother were going to the store and a group of youth walked up on them and stabbed his brother. David was so scared that he ran away. His brother was taken to the hospital and lived. David described feeling very "scared" and "worried" when this event occurred.

David witnessed another violent act in his life which was too traumatic for him to share during the interview. He would only divulge, "I don't want to talk about that—other one…About my sister…She died

already, my sister." David alluded to directly witnessing his sister getting killed during a horrible event which happened while the family lived in the Philippines. Later in the interview, David was asked if there were parts of the bad things which happened that still bother him, or memories that are harder to forget. He responded, "My sister." He was then asked to clarify weather it was harder because she died, or because of what happened to her. He responded, "What happened to her." The details of the event were not explored further because it did not seem clinically appropriate to risk re-traumatizing him.

Relationship to Victim/Victimization Experience

The relationship David has had with victims of violence appears to have profoundly affected him. Based upon his reactions, David's relationship with his late sister impacted his reactions of trauma and grief. This emotional impact was so overwhelming that David refused to discuss the specific event, or elaborate on his relationship to his sister.

Trauma

Based upon the *Children's PTSD Inventory* (Saigh, 2004), David has a diagnosis of Chronic Posttraumatic Stress Disorder. He described several situations which were traumatizing to him or which he witnessed

occurring to others. His reactions to these traumatizing situations are indicative of PTSD. He endorsed the required number of symptoms in the four main domains related to PTSD: re-experiencing; avoidance and numbing; increased arousal; and, significant distress. The majority of symptoms persisted longer than three months after the incident(s), which meets the criteria for Chronic PTSD. Specific descriptions of symptoms he endorsed are listed below according to the respective symptomatic category.

David endorsed all four symptoms related to situational reactivity. He said that he was scared and very upset when these incidents occurred. David felt that he could not do anything to stop the traumatic events from occurring. When asked whether he moved around or talked more after these events, David responded that he was "hyper."

David endorsed certain aspects of each of the symptoms related to the re-experiencing symptom cluster of PTSD. When asked whether he has upsetting thoughts about what happened, David reported that he tries to block out those thoughts. He added, "It's out of my life." However, he did indicate that images of the traumatic events continue to "pop into his head." He also said that he used to write stories about what happened.

David also endorsed having bad dreams about his sister getting killed and his brother being stabbed; with fears that it will happen again. David often feels that the events are happening all over again. He also becomes upset when he sees people, places, or things that remind him of the events. David endorsed two of the four physical symptoms related to re-experiencing the traumatic events. In situations that remind him of the events, David's hands feel sweaty and he gets a bad feeling in his stomach.

David endorsed six out of seven of the symptoms correlated with the "Avoidance and Numbing" symptom cluster of PTSD. He reports trying not to think, fell, or talk about the events which occurred. David reported having difficulty feeling things, or expressing his feelings to others. He had some trouble remembering parts of the traumatic experiences which occurred. David was less interested in things he used to like to do, such as play basketball. David did not endorse several of the PTSD symptoms related to avoidance and isolation. He continued to interact with people and places that reminded him of what happened, such as the store where his brother was stabbed. He also did not report isolating himself from friends and other youth his age.

David reported some previous depressive and suicidal ideations, when asked if these events changed his mind about his own future. David reported having the following attitude after the traumatic events which happened to his siblings: “Forget my life; I don’t want to live anymore, something like that. But my mom helped me—that’s why I changed my life.” David went on to explain how he initially felt that he was “cursed [because] all this happened around me.”

David endorsed all of the symptoms related to the *Increased Arousal* symptom cluster of PTSD. David experienced difficulty sleeping and concentrating. He became angry easily, yelled often, and got into many fights. David was also hyper vigilant, more guarded and watchful.

The significant distress which these symptoms caused David was also assessed. When asked if he has been more upset than before these events occurred, David said that he gets “angry” and “sad.” Related to problems with classmates, David reported that he has been getting into fights and “disturbing” in school. His grades have also gone down since the incident when the knife was pulled out on him. Related to family discord, David said that he got into more fights with his parents and siblings, especially after the incident which happened to his sister; and,

when David himself was threatened with a knife. Academically, David's difficulties include talking in class and arguing with his teachers.

Dynamics of Violence

David had an intriguing perspective on how he had become less violent. He did not have a clear answer as to why other youth were violent. He identified several sources of social support that helped him deal with his trauma and other difficulties, such as his family and counseling. However, when asked if these people helped him be less violent, David said, "No." He emphasized that the reason he was less violent was because he decided to be. When asked why he decided to be less violent, he responded, "Because I told you that I think I'm cursed like something happened to my life like I have been bad." David continued to explain how he is making a change from being "bad" to "good."

Risk Factors

The neighborhood where David lives presents a considerable risk factor for repeated exposure to violence. Both incidents of personal victimization occurred on the streets near his neighborhood. David's tendencies to fight and get angry easily also present risks for future exposure to violence.

Protective Factors

There were several sources of social and community support identified by David. The first source of support he identified was his mother. David said that he was able to talk to her and that she helped him to "take care about your dreams and hopes." Other social supports were his bets friend, his girlfriend, and the pastor at his church. These sources of support helped David to "talk about it" and focus on a new life and to forget the past. These people helped David feel hopeful instead of giving up.

Resiliency

David's sense of spirituality is a source of resiliency for him. His belief in God has helped him find new hope. He described going from feeling "cursed" and not wanting to live, to feeling more hopeful. Although David struggled with describing these beliefs in English, he conveyed the sense that his faith has helped him cope with the horrible things that have happened to him and those close to him.

Making Meaning

There was a spiritual aspect to the way in which David made meaning of the traumatic events which occurred in his life, and how he

has tried to heal from them. David said that he felt “cursed” when all of the bad things happened to him. He later elaborated that he felt that bad things were happening to him because he was “doing bad.” He added, “I think that I’m not going to live anymore or something like if I die and go to hell…” Now, he said he was trying to do better, and life is getting better. In broken English, David tried to explain himself, “I would change my attitude. I want to be new like…I want to make up…When I go home like and then go to school like that and get good grades….I don’t want to give problems to my family anymore.”

David was asked if there was something that happened to make him change the way he is from being “bad” to being “good.” He said that his Mom and God changed him. God and his mother helped David change from giving up to having hope.

Beliefs about Community Violence

When asked why there’s so much violence that happens to kids, David responded, “Because they’re bad like…they don’t want to do good and they start problems.” David was unable to elaborate much beyond this answer.

Recommendations & Solutions

At first, David did not have any answer for ways to “fix violence.” He then suggested,” Just don’t talk shit…Just keep right and don’t play rough…Don’t be mad... Don’t be hateful.”

Cynthia

Environment & Demographics

Cynthia is a seventeen-year-old first generation Chinese girl. She lives with her parents, grandmother, and her older brother. Cynthia lives in a neighborhood where there is a high rate of violence and criminal activity.

There were significant family and cultural dynamics which influenced Cynthia. As a first generation Chinese girl, she experienced considerable cultural conflict between her identity as an American Teenager and the expectations of her culture and family. She indicated that her parents had very little understanding about what her life was like (e.g., her interests, friends, challenges, and aspirations). Her family also imposed certain obligations on her, such as assisting in attending to the needs of other family members. Cynthia described an internal conflict between her individual identity and her cultural or familial roles.

Based upon the *Exposure to Community Violence Survey* (Richters & Martinez, 1998), Cynthia identified the frequency of different forms of violence that she has witnessed, rating them as follows: a) Many Times; b) A Few Times; c) Once or Twice; and, d) Never. Types of violence Cynthia has been exposed to are summarized below in order of frequency, followed by descriptions of specific events which were most significant or severe.

The following events have been witnessed by Cynthia *Many Times:*

I have heard guns being shot.
I have seen someone be arrested.
I have seen drug deals.
I have seen alcohol in my home.
I have seen gangs in my neighborhood.

The following event has been witnessed *Once or Twice:*

I have seen someone being beaten up.

Critical Incident

Cynthia identified two critical incidents which were scary and traumatizing to her. One involved being physically assaulted or "jumped" as she described it. The other event involved domestic violence in her home.

The incident of assault involved being jumped by other youth while Cynthia was coming home from her friend's house. The incident involved other youth who "just hit [her] a few times and then left." For Cynthia, her isolation was scarier than the assault. As she explained, "It is very scary 'cause what are you supposed to do? You're by yourself, there's no one there, you know?" She went on to explain how vulnerable the incident made her feel: "I had my cell phone and I was at somebody else's house…so, there's not really anything I can do…you have no proper transportation, 'cause who knows when the bus may come. You have no phone to call anybody so you kind of stuck in that situation. "The experience of being jumped while all alone had a lasting effect on Cynthia. She stated emphatically, "I don't ever go anywhere by myself."

The second traumatizing event identified by Cynthia involved conflict and domestic violence among her family members. The perpetrator of the violence was Cynthia's brother, who is nine years older than her. She described how she witnessed him hit her mother in the past. She said it was scary to see him hit her mother because he has hit Cynthia in the past also. Cynthia went on to explain how her brother's violence

and intimidation are not dealt with or discussed in her home; and, she alluded to this secrecy as being the norm in Chinese culture.

> When I was young, we used to get into these little fights and it was scary for me because our family, as many families, we don't talk about these things much, you know. As for our families, these just happen and they just cut them, let it be right there. We don't ever talk about how you feel about it. That's how our families live with it.

Relationship to Victim and/or Victimization Experience

Initially, Cynthia described her scariest experience as being the time when she was jumped. She felt that incident was the most threatening because she was all alone with no one to protect her. However, as the interview progressed, Cynthia's emphasis shifted and she began attributing more significance to her family problems.

> One thing, besides this jumping thing, like that thing to me is not that much 'cause I try not to think about it so much. But what I still think about is what goes on in my family. Cause it really makes me sad, you know, it really does affect me at times to see like my family are the way they are.

Cynthia admitted her concern for her mother, and her fear that her brother will threaten or hurt her. Witnessing her brother hit her mother appeared to be more traumatic to Cynthia than being hit herself by her brother. Cynthia appeared to feel a need to support her mother and protect her from the emotional abuse of her brother. Cynthia's sense of

family obligation definitely impacted the severity of her posttraumatic reactions to the family conflict she witnessed. As she stated, her own attacks became secondary to her concern for the well being of her mother.

Trauma

Based upon the *Children's PTSD Inventory* (Saigh, 2004), Cynthia has a diagnosis of Acute Posttraumatic Stress Disorder. She described situations which were traumatizing to her or which she witnessed occurring to others. Her reactions to these traumatizing situations are indicative of PTSD. She also endorsed the required number of symptoms in the four main domains related to PTSD: re-experiencing; avoidance and numbing; increased arousal; and, significant distress. The majority of symptoms did not persist longer than three months after the incident(s), which corresponds to the criteria for Acute PTSD. Specific descriptions of symptoms she endorsed are listed below according to the respective symptomatic category.

Cynthia endorsed three out of the four symptoms related to situational reactivity. She was scared and upset after being jumped. She also felt that she could not do anything to prevent the incident. She did

not endorse being more restless and active following the incident. Instead, Cynthia said that she was quieter after the incident occurred.

Cynthia endorsed four out of five symptoms of the *Re-Experiencing* Symptom Cluster of PTSD. She said that she continues to have upsetting thoughts about the incident; that the event "keeps replaying." Immediately following the incident, Cynthia had recurrent bad dreams, but these subsided over time. Cynthia has re-experiencing symptoms when she sees people, places, or things that remind her of the incident. One physiological reaction she experiences is an increased heart beat when she is in situations that remind her of the traumatic event.

Cynthia endorsed three out of the seven symptoms related to the *Avoidance and Numbing* Symptom Cluster of PTSD. She indicated that she tried to avoid thoughts and feelings related to the event. Cynthia also avoided talking about the incident and stayed away from people and places that reminded her of it.

Cynthia endorsed three of the five symptoms related to the *Increased Arousal* Symptom Cluster of PTSD. Since the traumatic event occurred, Cynthia reported that she got angry very easily and yelled at others. She also found that it was difficult to pay attention in class.

Cynthia reported being much more careful and watchful after she was jumped. Her hypervigilance continues currently and she is often afraid that someone will unexpectedly attack her again.

Dynamics of Violence

Cynthia felt that some of the main causes for youth violence were jealousy, envy, and petty conflicts. Most fights began over "stupid things." She elaborated, "Fights around here, it starts from the little stuff like it could be some girls talking smack to another girl over guys or someone stepped on your shoe."

Risk Factors

The primary risk factors for Cynthia appeared to be the violence in her surrounding environment as well as the strain and conflict existing within her nuclear family. Cynthia's violent attack was simply the result of the risks associated with the violent urban environment where she lives. She was not engaged in illegal or violent activity; but rather, she was merely walking home from a friend's house and victimized by other youth.

The family dynamics in Cynthia's home had the potential to produce several immediate and secondary risks for her. Her brother's

previous violent behavior and threats proved to be very oppressive for Cynthia. She described her brother's authority in the family as, "He's the one who has the power over the whole house." Cynthia added, "There's always the fear of him hitting you, so most of the time I don't say anything." Cynthia described how her father has confronted her brother in the past, and his violent behavior has subsided. However, Cynthia's brother continues to dominate the home and especially intimidate their mother.

Cultural factors combined with oppressive family dynamics make it very difficult for Cynthia to access genuine support from members of her immediate family. Cynthia described how distancing the cultural gap is between her parent's generation and her generation. She felt that her parents really did not understand what her life was like at all. This cultural gap increased Cynthia's alienation from her family. Her brother's oppressive presence added stress to the family, making it more difficult for Cynthia's emotional needs to be met. As she described her relationship with her mother," I've seen how she worries about my brother. So, it's like, I already feel like that's already enough for her. She don't need to

worry about me that much." Consequently, Cynthia never told her parents about her fears or traumatic experiences.

Cynthia further explained how it is culturally unacceptable for a Chinese family to ask for help outside of their family. Family problems are expected to be dealt with in the family, and acknowledging problems to others, especially outside professionals, can bring shame upon the family. As a result, Cynthia felt a strong compulsion to get away from her family and go away to college as soon as possible. However, her desire to leave was compromised by her sense of obligation to her mother, who would be left to fend for herself with her oppressive brother. Cynthia described how there is a compelling expectation to care for one's family in the Chinese Culture. Guilt can be used to motivate family members' obligation, as Cynthia's description of her family illustrates:

> They [my family] do put on like some burdens on me like I am supposed to watch my grandma sometimes, so, and she's like got [Alzheimer's Disease]…sometimes she doesn't even recognize us and I'm supposed to watch her and sometimes, when I'm not at home, she would leave the house and she'd be brought home by the Police before and I used to get blamed for that. So, they used to, my brother, used to put a lot on me. Now, he still does. He tells me like, "If she dies, it's your fault cause you aren't watching her." So, they put burdens like that on me.

Protective Factors

Despite her family difficulties, Cynthia had a strong support system consisting of close friends and adult confidants outside her family. Friends were an important source of support for Cynthia and helped her cope with many of the problems she faced. She said that one friend in particular was her closest friend who she felt was like a sister to her. As she described, "That's the one person I really trust and that's how I get through my pains." One way Cynthia's best friend helped her was to encourage her to take responsibility for her own part in conflicts.

Cynthia identified certain adults who were supportive and available to her; who provided some of the guidance her own parents were unable to provide. Cynthia said that her own parents were either busy working or preoccupied with their own problems to be entirely available to her. She also implied that she did not want to burden her parents with her own problems. The adult confidants who Cynthia confided in were some of her teachers as well as the staff at the violence prevention youth program. Friends and significant adults seemed to function as surrogate family members for Cynthia, providing her with the

necessary guidance and nurturance she could not garner from her own family.

Resiliency

Cynthia presented a certain self efficacious attitude combined with specific coping strategies which suggested that she was a resilient youth. She presented herself as a youth who with strong convictions to overcome the adverse conditions of her environment and living situations. She was determined to "get away" from her family problems and dangerous neighborhood. She planned to go to college and do more with her life. The stressors in her life appeared to be motivators for her. She enthusiastically described her goals: "I just want to really go and explore it and see what there is out there."

Creative expression was a personal method of coping and attaining deeper self-understanding for Cynthia. Writing was a way that she released upset feelings. As she described, "You just write when you're mad. You just spill everything out."

Making Meaning

Cynthia explained how she has matured as a result of the tumultuous experiences she had to overcome during her adolescence. The

violence she has witnessed or experienced among other youth has taught her to prioritize who she associates with. As she explains, she has learned to “really stay away from people that you know are a mess, like people that really aren’t going to do anything for you, except maybe make you do stupid things.” Cynthia described herself as concentrating more on her goals and future. She shared her aspiration, “I really want to go to college.” During her senior year of High School she said she wants to “really focus on my own self.”

Beliefs about Community Violence

Cynthia also felt that respect was a motivator for violence. She said that many youth fight because they want other kids to respect them. She said that people fight so that “no one will mess with them.” However, Cynthia felt that this behavior only led to increasing violence. She described how youth will continue to fight back and forth and the violence escalates in the name of “respect.” Cynthia felt that it was better to “not even start.”

Another reason, Cynthia presented, for youth violence, was loyalty to different neighborhoods and groups. She felt that youth often fought with each other because of the neighborhood or gang they affiliated with.

Thus loyalty and respect on a group level contributed to large scale youth violence.

Recommendations

School and community-based youth programs were the prevalent recommendations made by Cynthia for the problem of youth violence. She felt that the staff was helpful to youth like her who did not have other significant adults in their lives whom they could talk to about personal issues. She also said that violence prevention programs like Urban Players, helped inner-city youth to overcome their differences in peaceful and cooperative ways. As she stated:

> With UP, it's like people from all over and it seems like we're all different race and everything. And, it seems like we all get along so, I feel if we have more groups like that to get it together and like do things that they usually don't do…go out to see what else is there to motivate them how other people work. Like how their communities work out, then maybe it'll motivate them to change.

Exposure Level Four: Victims and Perpetrators of Community Violence

Trevon

Environment

Trevon is a Seventeen-year-old Filipino-American boy. According to Trevon, he "lives in two homes." Part of the time, he lives with his mother and siblings, who moved to a city twenty miles away from San

Francisco. His mother, three older brothers, and older sister live there. The other part of the time, he lives with his grandmother. His grandmother lives in an impoverished urban neighborhood which has a very high crime rate, especially illegal drug activity, prostitution, and violence. Trevon is supposed to attend school in the city where his mother lives, but he spends a great deal of his time in the inner-city neighborhood he grew up in and stays with his grandmother.

Trevon had been recently released from a Juvenile Detention Facility where he was detained for seven months. He was convicted for a "dope case" as he described it. At the time of the interview, Trevon was on Parole. When asked how things have been since he got released, Trevon responded, "Shit." He stated that he had to go to school, and he doesn't like school. He also said that his parole officer randomly comes to his house and inspects his possessions. He described a recent incident, "I just got cuffed up on Thursday because my Parole Officer came to my house shit and he was acting all bullshit and he just cuffed me because like I was being a little rude or whatever…" Trevon described how he is treated by the Parole Officer: "'Cause like he always come in my house once a week and run through my shit, right; like he goes through my bed,

he flips that shit over, and throws my clothes on the ground, and run through my pockets and shit." He further described how his Parole Officer confiscates any money he finds in Trevon's possession because Trevon "owes restitution" for grand theft auto.

Based upon the *Exposure to Community Violence Survey* (Richters & Martinez, 1998), Trevon identified the frequency of different forms of violence that he has witnessed, rating them as follows: a) Many Times; b) A Few Times; c) Once or Twice; and, d) Never. Types of violence Trevon has been exposed to are summarized below in order of frequency, followed by descriptions of specific events which were most significant or severe.

The following incidents have been witnessed by Trevon *Many Times*:

I have heard guns being shot.
I have seen someone be arrested.
I have seen drug deals.
I have seen someone getting beaten up.
I have seen a gun in my home.
I have seen alcohol in my home.
I have seen gangs in my neighborhood.

The following incidents have been witnessed by Trevon *Once or Twice*:

> I have seen someone pull out a gun on someone else.
> I have had my [car] broken into.
> I have seen someone get stabbed.
> I have seen someone get shot.
> I have seen someone in my home get shot or stabbed.

Trevon elaborated on some of the incidents of violence exposure and the violence related risk factors. Regarding the gun in his home, he stated that it is his brother's gun and it is always there. Trevon witnessed one shooting on a bus. He described how one of his friend shot someone else in the hand. As Trevon told the story, he laughed. When asked if he witnessed anyone shot in his home, Trevon described an incident when he was four years old, when his grandmother got shot by his uncle. Trevon considered the incident to be one of the more traumatic or "scary" events of his life; therefore, it is described in more detail under *Critical Incidents*.

During the course of the interview, Trevon vividly described the crime and violence which pervaded his neighborhood. He described many of the events as common place occurrences, which he claimed did not affect him very much, adding, "Shit happens." However, every time he described a shockingly violent event which he witnessed or

participated in, he nervously laughed. Trevon appeared to have developed a nonchalant and anxiously amused response to the violence and desperation surrounding him. He was asked if had ever seen someone get shot to which he responded, “I see how the dopies will jump off their house and shit and die. I see how people die.” He elaborated that he had witnessed two people jump off of buildings to their deaths in front of his eyes: “I seen them fly out the window, probably got thrown out but I think they jumped.” He added that it happens all the time, “[The Police] do the chalk thing and leave the body right there…I’ve seen it twice.”

Critical Incidents

When asked about specific traumatizing, or “scary,” events experienced directly or witnessed, Trevon described three different types of violence he experienced. One incident involved family violence when he was a child, and his grandmother was shot by another family member. The second incident involved Trevon getting robbed by other youths in his neighborhood. The third incident, involved the stabbing of one of his friends during a large scale neighborhood fight that Trevon was part of.

Trevon retold a critical incident of family violence which resulted in the accidental shooting of his grandmother. When Trevon was four

years old, his grandmother got shot right in front of him. The family conflict started when his uncle and his wife started fighting. Then Trevon's other uncle tried to break up the fight, "like chill him out." Then the uncle tried to shoot the other uncle who was breaking up the fight. As he describes, "My Uncle [Russell] tried to shoot my – the dude that was trying to stop it and shot my grandmother here – she got – she got one right here (Trevon gestures to left upper chest)." Trevon's grandmother survived the shooting. She is the same grandmother who he now stays with. Trevon went on to explain that the uncle who tried to break up the fight wanted to kill the uncle who shot Trevon's grandmother. He added, "He's still trying to kill him…This happened…like 13 years ago."

Trevon had difficulty admitting to having had "scary" events happen in his life. Several of the "scary" events had to do with his fears of being arrested or sent back to jail. When asked about scary events he laughed and said:

> Well I'm out there selling dope when I see the Police right and like I have rocks [crack] in my mouth and I can't swallow…And like they pull out but they don't say nothing; they just know me and shit, they just – they just there and tell me to leave; they don't hop out the car and take me and shit. I'll be – I'll be scared and shit.

Trevon did recount a recent incident in which he was jumped, or as he states having been "got" one time. The event occurred on a main street where many people shop, and where Trevon often goes. He describes the incident as follows:

> It was like nine niggers right and they followed me and shit. I was walking down here and they was like, 'man you already know the business.'…I had nothing on me. I didn't have the weed and I was walking and they seen me have gold teeth and I look like I got money and they just — they just run up behind me— and I knew one of the niggers; he was—I used to go to school with this nigger, but he didn't touch me. It was these two other niggers like, so like they pulled up right in front of me and I saw the nigger right because he was like…I already know I'm going to get jacked right. So I socked the nigger and run a little and he grabbed me by the coat. My coat come off and –Boom!—I'm on the ground right; I get back up and start running…So' I'll be traumatized from that; and I can't go—I don't like go shopping by myself and shit.

Trevon described another incident of community violence that involved a large-scale fight between his friends and other youth, which led to multiple stabbings of two youth. One of Trevon's friends was the perpetrator of one stabbing, while another friend was a victim of another stabbing. The incident occurred outside an illegal Gambling Casino in Trevon's neighborhood. Trevon described how he tried to avoid the violence:

> …Right before I got locked up and I wanted to do right like I saw the niggers come outside like 20 of them and we stabbed one nigger

> like 10 times and shit. My nigger like – I'm like 'oh I can't do this'; this is violence outside and I can't really do anything.

Trevon continued to explain how the violence quickly escalated between the two groups:

> They pull out [guns] in front of the car and shit…Even if we don't like it—shit and they pull out and they see Dukie, 'cause he's from 6th Street—they don't like each other and what not…And they see Dukie and shit and they booed him—Winston automatically takes off on this nigger right and starts shanking this nigger and all these niggers were bashing and shit, and Dukie, he's on the ground right. He rolls under the car and they're like—we were on the curb and he rolled under the car so you can't hit him but he's still trying to hit this nigger and there's only five of us out there and I can't do it with them; All right; I'm like what the fuck…So they leave Dukie right under the cars—just leave him crazy. We bring him out and he had to go to the hospital and everything. That nigger still walking around with a cast and shit….The arm is still fucked up and it's been almost five months—eight months already.

Trevon explained how the violence and retaliation between these two groups continued after the incident described: "It was like a war zone. What like we would walk around and we would see one of them and we would just beat their ass." Trevon laughed while he described how one friend "burned [another kid] with a cigarette in his eyes and shit." He added that people were beating each other up, fires were started, and "shit like that was just happening like daily."

Relationship to Victim/Victimization Experience

Trevon described several incidents of violence of which he was a victim, witness, or perpetrator. His relationships to the victims, or his personal experience of being a victim himself, will be described respectively. After describing the various forms of violence he experienced, Trevon was asked if he felt upset when any of these things happened to him like his friend getting stabbed, his grandmother shot, or getting jumped. Trevon's laughed and responded, "I'm like fuck—shit happens."

In reference to the family violence he witnessed as a four year old, the victim of the violence was Trevon's grandmother. She was shot in the chest while trying to mediate an argument between other family members. Trevon's grandmother lived through the shooting and is currently one of his primary caregivers. Trevon also indicated that one of his uncles is "still trying to kill" the other uncle who committed the shooting. Trevon did not indicate how his relationship to his grandmother was affected by the family violence, or specific worries or concerns that he had for her. He simply stated that she's alive now and he stays with her.

Trevon described the anger he felt after watching his friends be beaten up and stabbed during the many large scale fights he was involved in. When asked weather he was upset after the fight that resulted in his friend being stabbed, Trevon said, "Yeah; it made me—it made me pissed. It made me want to fight them niggers like—you know what I mean. All them niggers over here they all are my brothers…we're tight and shit." He later explained the loyalty he felt towards the other youth in his neighborhood, and the expectation to fight along side your friends in the neighborhood.

There were several instances during the interview when Trevon alluded to his fear of being arrested and put in jail again; therefore, juvenile detention and/or jail were most likely traumatizing to him. When talking about the most recent large scale fight he was involved in, Trevon stated, "I'm like fuck—I'm not scared about getting my ass beat that day. I was scared about going to jail."

Trevon described how he has been affected by having been robbed on the street by other youth. He indicated that he no longer goes shopping on the same street by himself. He is also more "on guard" than before. When he is reminded of the incident he becomes angry and guarded. He

has even seen some of the youth who robbed him: “Like when I see the same dude that did it I’ll be getting—fuck this up—and fuck this dude.”

Trevon described the physical sensations he experiences when a fight is about to occur:

> When like shit is about to go down I’ll be tripping and my heart is like fuck. I’ll be like—I get that shit. Yeah; I get that shit and it’s also I get the scary feeling because every get like—where a person is always scared—like you feel me, because like it’s—because like you always know that somebody you’re always going to meet your match, you know what I mean?

Trauma

Based upon the *Children’s PTSD Inventory* (Saigh, 2004), Trevon has a diagnosis of Chronic Posttraumatic Stress Disorder. He described several situations which were traumatizing to him or which he witnessed occurring to others. His reactions to these traumatizing situations are indicative of PTSD. He also endorsed the required number of symptoms in the four main domains related to PTSD: re-experiencing; avoidance and numbing; increased arousal; and, significant distress. The majority of symptoms persisted longer than three months after the incident(s), which meets the criteria for Chronic PTSD. Specific descriptions of symptoms he endorsed are listed below according to the respective symptomatic category.

Trevon endorsed three out of the four symptoms related to situational reactivity. He said that he was scared when these incidents occurred. An example he gave was that he can no longer go shopping by himself as a result of being assaulted and robbed. He endorsed feeling very upset when these events happened. Specifically, he said that he was "pissed off" when his friends got hurt and he was mugged. Trevon also felt that he could not do anything to stop the traumatic events from occurring. Regarding situational reactivity, Trevon was asked if he moved around a lot or talked more than usual after the traumatic events. He did not endorse this symptom, responding, "I ain't never talked about it…I just guessed it was like a usual thing, you know what I mean?" Trevon did however, indicate that he was "more aware of his surroundings" after being jumped.

Trevon endorsed eight out of eleven symptoms of re-experiencing the trauma. Trevon thought about the traumatic events which occurred; however, he did not report experiencing images of the events frequently popping into his head. Trevon reported frequently having bad dreams, some of which were related to traumatic events. Trevon said that he often feels like the traumatic events are happening all over again, like it was just

yesterday. He also reports being on guard. He gets upset when he sees or thinks about people places or things that remind him of the traumatic events, especially related to him being jumped. Trevon endorsed two out of three of the PTSD-related physiological reactions. In response to whether his heart beats more quickly when in related situations, Trevon rhythmically pounded his chest and said, “When shit is about to go down…my heart is like fuck.” He also said that he gets “that gut feeling” when in violence-related situations.

Trevon endorsed eleven of the sixteen assessment questions related to symptoms of avoidance and numbing as a result of PTSD. He indicated that he tries to avoid thinking about traumatic things that have happened to him. He also avoids his own feelings related to the event(s). Trevon also rarely speaks to others about upsetting experiences; as he stated, “Like when I got jumped I never ever – I never bring it up.” He said that he tries to stay away from people and places that remind him of traumatic events. This is especially true of the neighborhood where he was jumped. Following the traumatic incidents Trevon he lost interest in some of the things he used to like doing such as playing basketball.

Trevon did not endorse all of the symptoms of avoidance and numbing. In the aftermath of traumatic events, he remained close to his friends rather than isolating. Trevon also said that he had vivid memories of the traumatic events he witnessed or experienced. Recalling the incident of family violence, Trevon said, "Even my grandma's shit; that shit happened when I was four and I still known what the fuck happened."

Trevon endorsed five of seven symptoms of increased arousal related to PTSD. He did not have difficulty sleeping following the incidents. He did however, say that he yelled at his girlfriend frequently after the violent incidents; something which he claims he never did previously. Trevon got in more fights following the violent events; and added, "Yeah, felt like I wanted to fuck somebody up." Trevon became more guarded and watchful after his exposure to violence. He also became startled in response to loud noises.

Many of the symptoms which Trevon endorsed persisted for several months after the traumatic incident, and many symptoms remain for him today. Consequently, Trevon meets the diagnostic criteria for PTSD, Chronic Type. Physiological reactions continue to occur when he is

in a potentially violent situation, including: increased heart rate, stomach aches, and startle response. He continues to fight when he feels threatened or others close to him are threatened. He is guarded and hypervigilant. Despite his fearless attitude, Trevon admitted, “I’m scared all the time though.”

Dynamics of Violence

Trevon described himself as being immersed in a violent lifestyle; to the point that he became indifferent and numb. He is regularly involved in fights, as are most of his peers. There appears to be constant violence in his neighborhood. Trevon is both a victim and perpetrator of the violence around him.

Trevon told several accounts of violence in his community; however, according to his accounts he was actively involved in the violence, rather than being an innocent victim. When asked about the frequent fights he gets into in his neighborhood, he said, “We always fight right and like – actually it’s not scary; it’s kind of fun.” Trevon described a recent incident which seemed typical of the frequent neighborhood fights he is involved in.

> A couple days ago there was like a little incident with some people who were up there, right, like all of us. And like these older dudes

> was trying to come in and just help – like my friend was fighting this other dude and he was whooping his ass…And some dude tried to stop it and shit and the older dudes, right they're like 30 years old and shit trying to fight us and we're 18 and 17…And like that day right we was fighting, only we whipped their ass and they was leaking and shit and the next day right…the man come up on – it was just me, my two friends right, and it was like nine of these niggers in the car and they jumped out…with like had all the bats and shit and I'm like oh my God; so we started running and shit. And then we called everybody we knew blah-blah-blah, so everybody came down and we went in front of their house and like we came outside with our bats also so there was like 20 of us with bats. Just imagine that right and there were like 15 niggers in the house and shit, so we tell the niggers to come outside and shit right – squash it, because we live right next door to each other…And the dude come out and the Police come up and bring out the shotgun, the bean bagging shotgun…so I think the shit is still going on…And that night when we beat them and it got leaked up they beat my little nigger 13 years old with bats and shit. He got hit like six times and shit.

Trevon described a certain loyalty and code of conduct concerning the violence which occurred in his neighborhood. There was a level of protection he felt from others and a responsibility to protect them. He said that his neighborhood is safe for him: "They don't fuck with me. They know if they fuck with me they're going to fuck with all of us." When asked if he could walk away from large scale fights like the one described, Trevon answered, "Hell no!'Cause you wouldn't be able to show your face here again." He described the neighborhood loyalty as follows: "It's

like saying me and you – you're my brother right; we're fighting and you're going to just leave me there right? Like I'll beat your ass, right?"

Trevon described a certain cold indifference to the effects of chronic violence on him. As he stated, "I'm a hood nigger; you know what I mean? I don't feel shit." He went on to explain how someone could take his girlfriend he's had for three years, and he "wouldn't feel shit." "Like two niggers could just walk over there and shoot that nigger right there, I would be like what the fuck – he just got shot – what the fuck," added Trevon with a laugh.

When Trevon was robbed by other youth, the most disturbing aspect for him was that he was the victim. Usually, he is the person robbing others, not the victim. He stated, "That's my first time a nigger ever tried to come at me…I do the shit to people. Niggers don't do this to me."

Trevon also described many acts of crime and violence which he committed, conveying little remorse. When describing violent acts committed towards himself or those close to him, he conveyed little sadness or other appropriate affective responses. He described feeling

angry during certain situations. During the interview, his most common affective response was to laugh after telling vivid stories of violence.

Trevon was asked if there were people in his neighborhood who might hurt or threaten him, such as individuals addicted to drugs – "crack." He responded with laughter, "Desperate crack-heads know not to fuck with us…We beat the fuck out of too many crack-heads…I done beat the fuck out of 55 fucking crack-heads probably." When asked how that made him feel, Trevon responded, "Makes me feels safe…Makes me feel a little safer when I beat these mother fuckers' asses." Trevon was then asked how he feels when he later encounters a "crack head" he beat up before. He said, "It makes me feel bad for this nigger…I feel desperate for these fucking crack-heads. It ain't my fault they're smoking this shit."

Risk Factors

Based upon Trevon's interview, there are several risk factors which cause him to be susceptible to additional violence and other negative experiences and outcomes. He has a history of involvement in criminal activities. Trevon rarely attends school. He uses alcohol and marijuana on a regular basis. He also continues to associate in high crime and violence neighborhoods with peers involved in similar activities.

Trevon discussed the criminal activities he has been involved in. Specifically, he described selling and distributing illegal drugs, assault, and robbery.

When asked about drug use, Trevon said that he “smoked weed” but has quit for nine months due to his parole and required urine tests. When Trevon was asked how he got through all the violence and trouble he experienced, he responded with laughter, “Smoke.” He went on to explain how “when you smoke you get your mind off of that shit sometimes—like the weed keeps you laughing and shit.” When asked if he smoked “crack,” Trevon laughed and responded, “Hell no….That’s a rule…you don’t get high on your own supply.” Trevon described how he used to have a specific corner in the neighborhood which was his territory where he sold drugs. When he dealt drugs he had a large amount of money. Since his arrest and parole, Trevon has not resumed the lifestyle of drug dealing, and therefore has very little money. The temptation to return to dealing drugs is definitely a risk factor for Trevon. Being arrested for violation of his parole and sent back to jail is an additional risk factor that is very real for him.

Trevon's troubles with the education system, and subsequent marginal education, are other risk factors. He described his progressively worse school history. He said that he was a decent student and did not get into trouble when he was younger. Then in middle school he was expelled, and the reason he gave was, "they caught me fucking like a bitch in the bathroom." He added, "Every school I went to I got expelled from- suspended from them at least 10 times." As time progressed, Trevon went from attending school regularly to rarely attending. "I stopped going to school 'cause like—all my niggers dropped out and I had nobody to go to school with." Currently, he is enrolled in a school in his parents' own which is about 40 minutes from the main city. He is forced to attend school as part of his parole. Trevon said that he hates going to that school, because he doesn't know anybody, and does not fit in because they are a "bunch of nerds."

Trevon's peers present both risk and protective factors for him. In many ways he describes them like family, and is able to rely on them for support and protection. However, his peers are involved in similar criminal and violent activities. Many have dropped out of school. Although they are loyal and supportive friends, Trevon's peers are not

good role models for him and may help perpetuate the cycle of crime and violence he is involved in.

Protective Factors

There are several potential protective factors operating in Trevon's life. Trevon identified sources of social support in his life, including his family, friends, girlfriend, and community resources such as church. Trevon's involvement with the Juvenile Justice system may potentially be a protective factor because it can be a deterrent to further involvement in criminal activities.

Trevon repeatedly alluded to his fear of returning to jail, and how that has impacted his behavior. He said that he no longer "sells dope." He explained, "It's probably 'cause I've been going to jail and shit…I'm so happy to be out right now…..I get to eat whenever the fuck I want and shit and it's cool."

Family was identified by Trevon as an important source of support in his life. He expressed some regret about how he has disrespected his family. He said that after the all of traumatizing events he described, he got into more fights with his parents. Prior to that period Trevon said, "I ain't never yelled at my ma….I used to show respect and shit." He

described how his relationship with his mother has changed: “I forgot how to like—to say I love you…I used to tell my mother every day—like I forgot to show her respect and shit.” Trevon appears to have started to value the support of his family, which may prove to be a protective factor for him.

Trevon appeared to have very strong allegiances with his friends. He described the loyalty they had for each other, and ways in which they protected and cared for each other. This sense of belong can be a protective factor; however, the violent and criminal involvement of many of Trevon’s friends may also lead to more risk-taking behaviors.

Trevon said that he was able to talk to his girlfriend about things that he could not share with most other people. When asked if there were people he talked to when he was mad or upset, Trevon said that the only person he did speak to about his feelings was his girlfriend. “I’ll be telling her like when I’m scared and shit. Yeah; I do talk to her a lot. She’s probably the only person in this world I do talk to.”

Church has been an important aspect of Trevon’s life. He said that he has been going since he was born. “I go because I guess it’s just real to me and I believe in God and shit,” he added. He went on to explain how

life has gone better for his family and relatives since they have become more involved in church.

Resiliency

Trevon's most resilient quality appeared to be his tendency towards self-preservation. He tended to watch out for himself and take care of his own needs first. As he stated, "I'm a hood nigger…I don't feel shit." This hardened quality could be viewed as detrimental to him. However, he also felt that it was a quality which protected him from physical and emotional harm.

Making Meaning

Trevon did not explicitly describe exploring deeper meaning as it related to the violence he experienced. Instead he tended to laugh the events away, stating that they did not affect him. Beneath his laughter and toughness, there was desperation in Trevon's demeanor.

Trevon was vocal in describing the inequalities which perpetuated and justified his self-preserving lifestyle. At one point in the interview, he confronted the interviewer about the differences in lifestyles and perspectives.

> You come in here swinging your dough around and shit—throwing $25 for a nigger to talk to for 45 minutes, I mean shit. Well

> you can be some rich ass therapist but we over here-we over here hungry—feel me?

Beliefs about Community Violence

Trevon believed that there will always be violence, guns, and crime. He summarized his fatalistic view of the problems of inner-city poverty, crime and violence:

> There's always going to be guns; there's always going to be jealous as fuck-face ass-niggers, you feel me? There's always going to be violence. If I stop dealing – well see, I've already stopped dealing. They've already got another nigger taking my spot.

Recommendations & Solutions

Trevon had no recommendations or solutions for youth violence. He emphasized, "Nothing ain't going to fix the violence right."

Raheem

Environment

Raheem is an eighteen-year-old Polynesian male. He lives with his mother and his brother and sister. Raheem and his family live in a neighborhood where there is a very high rate of violence and crime. A large percentage of the violence is due to conflict between two neighborhoods in very close proximity of each other.

Based upon the *Exposure to Community Violence Survey* (Richters & Martinez, 1998), Raheem identified the frequency of different forms of violence that he has witnessed, rating them as follows: (a) Many Times; (b) A Few Times; (c) Once or Twice; and, (d) Never. Types of violence Raheem has been exposed to are summarized below in order of frequency, followed by descriptions of specific events which were most significant or severe.

The following incidents have been witnessed by Raheem *Many Times*:

I have heard guns being shot.
I have seen someone arrested.
I have seen drug deals.
I have seen someone getting beaten up.
I have seen someone get shot.
I have seen alcohol in my home.
I have seen gangs in my neighborhood.
I have seen someone pull a gun on another person.

The following incidents have been witnessed by Raheem *A Few Times*:

I have seen someone get stabbed.
I have seen a gun in my home.
I have seen someone in my home get shot or stabbed.

Raheem described numerous fights that he had been involved with growing up which often involved large groups of youth. One of many

frightening incidents described by Raheem involved a large scale gang fight. He described how the fight escalated to a point when people were using weapons like crowbars to hit each other. Then a member of the opposing gang tried to use his car to run over Raheem and his cousin. He reported that he and his cousin had to go to the hospital and have their wounds stitched up.

Raheem reported being a direct victim and witness to several acts of community violence. He stated that he was stabbed three separate times. He saw numerous people shot, including friends and family. Raheem described being surrounded by violence throughout his childhood.

Critical Incident

The most traumatizing act of violence Raheem experienced was having his life threatened by another youth at gun point. He described how the incident began based upon ethnic differences between Raheem and the perpetrator. A stranger to Raheem approached him on his way to school and asked Raheem, "You know what race I was?" Raheem answered him and the youth attacked him. The other youth and Raheem had a physical altercation which immediately escalated. The other youth

pulled out a gun on Raheem. As Raheem described, "Basically it was three inches away from my left eye. I stared down the barrel for three minutes. I was frozen…Point blank at my face."

Raheem felt that the threat to his life was racially motivated. As he explained:

> This is a racist act of violence. That's it. I've seen many acts of violence, right, but you know ….I understand all that irony in that and like how everybody say this and everybody say that. But the real story behind it is like they took the whole context and made it all a racial issue. My case is you ask me one question and I gave you an answer and hey, let me walk. I didn't do nothing there to provoke anybody.

The incident with Raheem triggered large scale fighting between different ethnic groups for several months. Raheem described the racial neighborhood fights which were precipitated by the gun-related incident. After his family realized what had happened to him, Raheem said that his extended family tried to retaliate. He saw the person who pointed the gun at him, and Raheem's brother tried to shoot him.

> I told him get back in the car. We just went on. From then on, it was like a war for like seven months. It was basically my race against their race but it wasn't anymore of the race, it was like their set their race against mine. And there was a couple of cases where they tried to shoot at us but, nothing big, it was just mostly a lot of shots in the air.

However, Raheem said that he did not want revenge against the perpetrator or his gang. As he stated,

> I didn't want no revenge, period. I wanted to get an answer as to why, you know? You know, they asked me what I was, I gave them the answer, I was walking away, it doesn't make sense for them to jump me. A lot of it made sense but that was one of them that didn't.

Relationship to Victim/Victimization Experience

Raheem described how he felt when his life was threatened by a gun pointed in his face. He described feeling "stuck" and seriously wondering whether he would die during the incident. He described the event, "Somebody for once, really put it up and I didn't know if he meant it and he was ready to kill me."

Trauma Symptoms

Based upon the *Children's PTSD Inventory* (Saigh, 2004), Raheem has a diagnosis of Posttraumatic Stress Disorder of the Chronic Type. He described being a victim of an event which was traumatizing and his reactions were indicative of PTSD. He endorsed the required number of symptoms in the four main domains related to PTSD: re-experiencing; avoidance and numbing; increased arousal; and, significant distress. The majority of symptoms persisted longer than three months after the

incident, which meets the criteria for Chronic PTSD. Specific descriptions of symptoms he endorsed are listed below according to the respective symptomatic category.

Raheem endorsed all of the four symptoms related to the *Situational Reactivity* typical of a PTSD diagnosis. He stated that he was very scared and upset when the gun was pointed in his face. He also said that he felt that he could not do anything to stop the event from happening. Raheem also indicated that he felt more restless and agitated for the first month after the threat.

Raheem endorsed all of the five symptoms related to the *Re-Experiencing* symptom cluster for PTSD. He indicated that he had a lot of upsetting thoughts about what happened, especially during the first two months following the assault. Raheem said that images of the event kept popping into his head, especially when he slept or when he "used to get high." He also indicated that he often felt as if the assault "just happened yesterday" long after the event occurred.

Initially, situational reminders of the event triggered re-experiencing symptoms for Raheem. When he was around people or places that reminded him of the event, Raheem had specific physiological

reactions. He said that when he saw people that remind him of the incident, “part of me wants to clench my fists, my palms will always get sweaty…I breathe fast.”

Raheem endorsed five of the seven symptoms pertaining to the *Avoidance and Numbing* symptom cluster for PTSD. Initially, he said that he avoided talking about the incident because he did not want to brag about it as other youth often do; and he added, “It’s not something to be happy about.” Raheem said that he did not avoid thinking about the event, but he did try to block out his feelings related to it. Initially, Raheem said that he did avoid places that reminded him of the incident. He also stated that he usually “kept to [him] self.”

There were aspects of the event which Raheem had difficulty remembering. He stated that he “blanked out” during the event and was only able to concentrate on the gun and was unable to attend to any other details of the event. Raheem described the experience as follows:

> Do you ever sit there and you watch something, you watch a whole movie and like the whole movie focuses on that one thing and everything else starts to tune out and you’re deaf. When you hear people talking you’re not aware that…Every thing was turned down and it was my whole focus was on what was going to come out of the gun.

In regards to numbing reactions, Raheem had an uncharacteristic response. He was asked whether it became difficult for him to feel things or show others how he felt following his traumatic experience. He responded, “No. It opened me up a lot.”

The event also resulted in a positive change in regard to his outlook for his own personal future. He was asked whether he had changed his mind about getting married or being a parent since the traumatic incident. He said that he always wanted to get married and have children. But now, he added, he would rather adopt some kids. The reason he gave was that “there is a lot out there that really don’t get their fair share.” Raheem emphasized that his life-threatening experience made him realize, “I want to be a real big role in their life.”

Raheem endorsed four out of the five symptoms related to the *Increased Arousal* symptom cluster for PTSD. Raheem indicated that he had difficulties falling asleep after the incident occurred. He also said that he got angry very easily for approximately a month after the event. He described his experience as, “It was basically like you know how you get a lot of emotions built up and all of a sudden you just need to rant.” Raheem got into more physical fights than usual immediately after the

traumatic incident. He experienced some difficulties concentrating and paying attention in school after the event. Raheem elaborated that he found himself thinking a lot more about “the whole life situation.” The life-threatening event seemed to cause him to re-evaluate his own life and “think a lot more.”

Raheem describe the *Significant Distress* caused by his posttraumatic reaction as becoming “implosive.” He elaborated,

> You got two types of people. People that explode and people that implode. An explosive type of reaction is like somebody who let’s loose everyday. It’s like a volcano… Implode is like a nuclear bomb. It builds up to that point and once it happens, what happens after is crazy…being implosive is one of the scary things to have because you never know when you going to let loose, you never know when you are going to snap.

Raheem described several trauma-related symptoms which persisted long after three months, such as his “implosive” anger. However, many symptoms were most severe during the first month or two after the event, and gradually subsided. Therefore, Raheem meets the diagnostic criteria for Chronic PTSD, with some symptoms of Acute PTSD.

Dynamics of Violence

Violence was a part of Raheem's life from an early age. He described how corporal punishment is an acceptable form of discipline in his culture. He even added, "In a Polynesian community, certain families go beyond the whole abuse thing." In regards to his own childhood, Raheem said, "You know, you get beaten so much by this stuff that I really questioned my Mom's love when I was young." When asked whether the violence he experienced as a child affected his behavior later in life, he responded, "Oh, a lot." Raheem was asked whether his childhood or society influenced him being violent later in life. He responded to the question, "I can't put all the blame on one. Both have a big role. They both play a big role in what I did. But again, it was my actions…By being influenced by it."

There were certain values and codes of conduct which Raheem adhered to pertaining to his own to violent behavior. He experienced a level of remorse following physical altercations, or robberies, during which he harmed another person. Raheem described witnessing an act of violence committed against someone else which profoundly changed his

own violence-related behavior. He was riding the public bus and watched as a group of boys rob an older man on the bus.

> I just watched it like it was the first time I just seen it…I was just sitting there, minding my own business and these kids jumped this guy and he didn't have no money. Then he stopped him and threw him of the bus. And he just kept stomping him and stomping him.

He said that watching the robbery made him feel bad, and think about times he robbed people. He further explained how he only robbed people out of necessity. He compared the difference between robbery out of necessity versus robbery and assault for the sake of excitement and desire. He compared the two situations as follows:

> Well, if it comes to the point where it gets bumpy, you got to make ends meet… I mean I got to eat. But this time [on the bus] it was really about someone else wearing this, let's go get it. I need it, I need it, you know. Let's go get it. I got it, let's go home.

Raheem always tried to avoid hurting anyone when he committed a robbery. He described his desire to avoid violence and his reaction to situations which became physically violent as follows:

> They just go home clean. Even if you go face to face, let them go home clean. I just hate it when I have to hit a person 'cuase it's like "Fuck! Why you got to hit him?" Then they go home, they all busted up. You go home, you got what you want but then again, it's like you had to leave a mark on that guy. I don't like that, I like things clean.

Raheem summarized his view of youth crime and violence: "Like people don't got the same morals. Like I remember…just like it brings you back to the story of Robin Hood, only robbing the rich to give to the poor."

Risk Factors

There were several social, environmental, and personal factors which have placed Raheem at high risk for exposure to community violence and other negative life events. Raheem's early childhood experiences and family dynamics may have increased his risk of involvement in community violence. He came from a household, and larger cultural community, where there was significant poverty and severe corporal punishment was a common form of discipline.

Crime, violence, and poverty were common childhood experiences for Raheem. Raheem described how he was indoctrinated into the inner-city criminal lifestyle at a very young age. He described himself as having experienced many of the life events urban adolescents deal with, before he was out of middle school. As he describes it, "By the time I got to, you know, the age I was supposed to ride a bike, is when every body [said]…'No! You know, he's ready to hold his own piece.'"

Raheem went on to describe how his uncle educated him about the world of dealing drugs. He described his relationship with his uncle as follows:

> He used to love working with crack. So, I knew a lot about methamphetamine and all those drugs… He really informed me about it. Said, if I ever catch you with a needle, I'm going to whip your ass. If I ever catch you with these things, I'll whip your ass… What he would do was to show me what drugs he had, he'll tell me the people he'd sell it to… I just look at him and he like, 'You want to be like that?' He scared the shit out of me man. I'd seen this lady just start jerking off and shit and start shooting up all this crack, and I was like , 'Wow!'
>
> This was when I was six…For three years straight, he made sure I knew what was what, you know, what to do in certain situations. But he, not once was I ever really…part of his whole drug process.…He made sure he didn't put no family involved with him…Every kind of drug deal I worked just like my uncle did. I ain't doing no family, none of them is in the business.

Raheem's involvement with his uncle taught him the trade of dealing drugs, which placed him at greater risk for criminal activities and drug use. However, his uncle's modeling also served a protective role because Raheem was exposed to the detrimental effects of street drugs by observing the effects on his uncle's "customers." Raheem learned certain "rules of conduct" for dealing drugs, such as: "don't get high on your own supply," not dealing to family members, and "knowing your customers and your product." Therefore, Raheem's relationship with his uncle

placed him at risk for criminal activity, but also protected him from some of the related dangers and risks.

Raheem had problems with the law from a young age, and spent a large portion of his youth in juvenile detention facilities. He spent three years in a juvenile detention facility after being charged with armed robbery. He said that he was charged with armed robbery because someone else was hurt. Raheem was also involved in auto theft, but claimed he was more excited about the thrill of taking the car on a "joy ride" than money from the theft. He claimed that he always put the cars back to their original location after he took them for a ride. As he stated, "I never fucked with the car, I would never steal a car and I'll put it back where I got it."

Prior to his life-threatening incident, Raheem said that he got into a lot of fights. He described his High School years as mostly about fights. He also explained the high level of fighting which occurred between different neighborhood groups. Loyalty was a contributing factor to many of the fights that he got into. Several fights that Raheem described involved protecting younger family members, cousins, or friends.

Therefore, Raheem's family and peer relationships were contributing risk factors.

Protective Factors

Family was a strong protective factor in Raheem's life. He identified certain family members who played important roles in his development. Raheem stated that his Mom was directly related to him avoiding violence. As he stated, "Cause I got to live another day with Mom. Like I get to wake up to see my Mom… I always told myself, I don't want my Mom to bury me, I want to bury my Mom." Raheem described being closer to his mother now. He explained, "I grew out of the whole hard headed ass stage, I really became close to my mamma. I really didn't take things for granted no more."

Raheem also identified his grandmother as being a positive influence. He said that "she was the strongest." Raheem's grandmother instilled a sense of faith and spirituality in him. Raheem conveyed his grandmother's message as the following:

> Well, you have to have faith in God. And she said, you know, I'm not pressing you to believe in God. Just have faith in what you do. And have the will to survive. That's what she told me.

Resiliency

One resilient quality was Raheem's street sense for dealing with violence. He explained,

> It was drilled in from my Mom as well as it was from the environment, the environment you grow up in, like in the hood or in the ghetto, wherever you grow up in, they teach you certain things. Certain places they teach you not to fight, other places they teach you you've got to hold your ground cause ain't nobody going to hold your hand when you walk out the house. It's you, your clothes, and your mind, that's it.

Raheem described several potentially dangerous situations in which he made rational decisions and acted with a certain level of self control. There were violent situations during which he needed to defend himself, and those which he could avoid. There were also situations in which he needed to "hold his ground." He was neither recklessly violent, nor was he entirely passive. Raheem appeared to have acquired an advanced capacity to navigate the often life-threatening domain of urban violence.

Creative expression was identified by Raheem as a major means of coping with violence and other upsetting experiences in his life. He processed many of his life experience through creative media such as writing and visual arts. He described how writing relieves his anger:

> Every time I get to have a pen and paper in front of me, everything just goes away to the pen. And my whole stress, everything goes from my body straight to the pen and onto the paper. By the time I'm done and I'm reading my product, I forget about it.

Creative writing and visual arts were powerful tools for Raheem during his adolescence. A group of street artists had taught Raheem how to do graffiti in a stylized and artistic manner. He explained how they taught him "the trade." Raheem summarized the protective influences which helped him survive adolescence amidst such urban violence.

> They [the street artists] taught me like if I can express myself, I express myself through art. So that, that and my Grandma's words were the two main things that really pushed me through my whole fucking up stages.

Making Meaning

Raheem indicated that surviving the threat at gun point was pivotal in changing his lifestyle and perspective. He implied that each person has a specific experience which can cause them to change. He emphasized, "No one's going to change until it happens to them." In reference to his own experience he stated:

> It really helped me out a lot…I grew out of the whole hard headed ass stage. I really became close to my mamma. I really didn't take things for granted no more, really…Now, I really appreciate a lot of stuff….At the end of the day, you got another story to tell your kids…or somebody who's willing to listen.

The experience of growing up in the violent inner-city inspired Raheem to possibly pursue a career helping other inner-city youth. He described what inspires him about the helping professions.

> You get chance at the spur of a moment where you can change their history and their life. Or you can actually influence them to a certain degree…I really want to do something like…you know how they have Big Brothers? I want to take Big Brothers to a whole new level.

Beliefs about Community Violence

Raheem had certain beliefs about what causes individuals to lead more violent lives, and alternative protective resources. In regards to why youth become violent, Raheem answered:

> A lot of people say it's the childhood. That isn't the right thing. There's some other things. But even growing up, it's just the whole process of growing up. Who do you have or what do you have. That support system. It's like I said, everybody and everything in your life is a light. And if you have no lights, your future is blind.

When asked what kind of support is helpful, Raheem responded,

> Whoever who's willing to love you, listen, be there for you…It doesn't have to be Mom or your Pop or your brothers or your sisters. It's just if you get that somebody, you found you a light, a value to your life.

Similar to many of the other subjects, Raheem felt that many fights were the result of insignificant conflicts which escalated into physical

violence. According to Raheem, the cause of violence "All starts with something small…petty shit…hate for one person that won't go away."

Recommendations

In regards to recommendations for the problem of youth violence, Raheem focused upon the most effective ways to reach at-risk youth on an interpersonal level; as opposed to social or programmatic solutions. Raheem felt that it is important for adults to allow youth the opportunity to form their own values and opinions; that there is a dialogue between supportive people and the individual. He said that one approach which was not helpful for at-risk youth was "nagging." As he stated, "Like you can nag on them but there's a particular way of nagging that pisses kids off." He recommended, "People ought to be genuine to the person, give them time to breathe."

A caring and consistent support system was considered by Raheem to be the most important solution for community violence. "The main thing you got to do," he said, "is to be a recurring thing and then like don't be just telling them to do something once in awhile…they establish the fact that you are in their life."

Qualitative Results II: Cross-Case Analysis of Categories

The second phase of qualitative data analysis involved cross-case comparison of common themes. This was conducted in order to distill those themes which were most prevalent across the twelve cases. This process of qualitative data analysis also reveals patterns relating to the experiences under investigation. This section is divided into the twelve dominant themes identified during initial data analysis. Then themes were presented which were subsumed under these dominant categories. Themes were presented based upon frequency across the twelve cases. A general description of the theme is presented followed by select case-specific illustrations.

Environment

The environments where these youth lived greatly impacted their exposure to community violence; as did the schools they attended. Most of the youth came from lower socio-economic backgrounds and lived in relatively impoverished neighborhoods. There was a broad range of ethnic diversity among the youth in this study. Cultural factors were identified as being influential by several youth. This section first presents general demographic information, followed by cultural factors. Then this

section addresses the chronic community violence in the environments where youth lived and attended school.

Demographics

There were a total of twelve subjects interviewed for this study, ranging in age from twelve to eighteen years of age. There were six males and six females interviewed. The youth interviewed for this study were from diverse ethnic backgrounds. Table 1 presents the demographics of the subjects. All of the subjects interviewed lived in impoverished inner-city neighborhoods where there was a high prevalence of violence and crime. The family constellation of the youth interviewed varied, but most lived with one or both of their biological parents and siblings.

Community Violence

All of the youth interviewed had been exposed to chronic community violence for the majority of their lives. They reported dealing with constant reminders of the violence surrounding them; as well as, isolated incidents which were particularly distressing. The history and type of community violence experienced by the youth appeared to affect the reaction of the youth.

Cross-case analysis of responses to the *Exposure to Community Violence Survey* (Richters & Martinez, 1998), indicate that there were forms of community violence commonly experienced by all of the subjects. Every youth reported hearing gun shots with the frequency ranging from a few times to many times. Most of the youth had also witnessed gangs in their neighborhoods, drug deals, and arrests. Several youth had also seen someone beaten up. The Exposure to Community Violence Survey (Richters & Martinez, 1998) included some items which were experienced less frequently, but could be considered more traumatizing than others. These included acts of violence such as: witnessing someone get shot or stabbed, a shooting in your home, or seeing someone threatened with a gun. These events were witnessed less frequently, and by fewer youth, but were experienced nonetheless.

Trevon and Raheem had both witnessed a family member get shot or stabbed in their own home. They had also witnessed stabbings and shootings, and Raheem had been stabbed several times himself. James and Raheem had both been held up at gunpoint. Several youth had witnessed someone shot and/or killed in front of them. Although these incidents

were not as chronic as other forms of community violence, such as hearing distant gunshots, they were more intense and memorable for the youth.

Several youth described being more aware and vigilant regarding community violence after they had experienced an event which was personally traumatic. Yvonne and Tonia both described being much more on guard after witnessing someone shot and killed in front of them. Witnessing someone killed at the age of eight caused Yvonne to avoid going outside in her neighborhood for several years. Tonia described noticing the violence around her much more after her friend died. Trevon was more aware of the potential threats in his neighborhood after being robbed. Jordan described how he hid under his covers when he heard gunshots after the death of his cousin.

Numerous subjects described how their reaction to chronic community violence changed after they experienced a particularly upsetting act of violence. Common post-trauma reactions to community violence were: hypervigilance; startle response, especially to the sound of gunshots; avoidance of reminders of the violent act; and increased arousal and physiological symptoms. Youth reported having very few posttraumatic reactions to community violence before experiencing a

specifically traumatic event. However, following a traumatic event, multiple forms of community violence appeared to repeatedly trigger posttraumatic symptoms.

Critical & Traumatic Event(s)

The youth interviewed identified a range of events and situations which they subjectively considered to be "scary" or traumatizing. "Scary" experiences for these youth ranged from hearing about the death of a close relative, to being the direct victim of assault with a deadly weapon. For one young man, the threat of being sent back to jail for parole violation was a serious threat which caused him considerable fear and anxiety. Conversely, there were experiences which many would consider traumatic, that youth did not consider being "scary." Raheem casually stated that he had been stabbed three times, but that was no big deal compared to the gun pointed in his face. Trevon laughed as he described having watched two "crackheads" plummet off rooftops in his neighborhood. Thus, there was a great deal of subjectivity in what each youth considered to be a "scary" or traumatic event in his or her life.

The four categories of violence exposure and type of trauma were: vicarious victims; direct witnesses; direct victims; and, victims and

perpetrators. There was a vast continuum related to the severity of traumatic events that subjects had witnessed or experienced directly. On the least exposed end of the continuum were the two youngest subjects, Jordan and Tamika, who did not report being victims, or directly witnessing a traumatic event. They did however, experience vicarious traumatization due to the violence inflicted upon people close to them. On the opposite end of the violence exposure continuum was subjects like David who witnessed the death of his sister; or, Raheem who had been stabbed several times and had his life threatened at gunpoint.

Perceived Threat

The level of perceived threat influenced posttraumatic reactions. Youth who felt that their lives were truly being threatened, identified those moments as the most "scary." Cross-case analysis showed that the threat of being killed (or of someone close being killed) was more traumatic than a less severe direct assault. For example, Raheem was more scared by the gun pointed at his face, than he had been during countless gang fights. Similarly, James' scariest moment was when he and his mother were held up at gun point. Interestingly, his greatest fear was that they would shoot his mom, not that he might die.

Vicarious Traumatization

Several subjects reported significant distress and PTSD symptoms due to violence inflicted upon people close to them, even when they were not direct witnesses to the events. Subjects reported PTSD symptoms related to events which they were not directly involved in. Jordan met criteria for chronic PTSD, even though he did not directly witness the events that he self-identified as the scariest and most traumatizing. Jordan's re-experiencing symptoms include hearing his cousin's screams through a cell phone; or, flash backs when he sees things that remind him of his cousin. Thus, his symptoms were not sensory experiences remnant from witnessing the actual traumatic event; but rather, were vicarious associations to the traumatic event that happened to someone close to him.

Vicarious traumatization was experienced by many youth as a result of the extraordinary number of people they knew who had been suddenly killed as a result of community violence. Most subjects did not initially identify these events as traumatic or "scary," because they were not direct victims or witnesses to the events. However, the majority of subjects described considerable distress following the deaths of people

close to them. Vicarious traumatization appeared to be an overlap of grief and trauma related symptoms. Following the violent deaths of others, subjects described symptoms of increased arousal such as hypervigilance and increased anger; as well as, symptoms of avoidance, numbing, and depression. The relationship to the victim was the most significant variable affecting the severity of vicarious trauma reactions.

Witnesses: Trauma to Others

The severity of the violence witnessed seemed to impact traumatic reactions. All of the subjects who witnessed someone killed in front of them had some posttraumatic symptoms; and, those with relationships to the victim had more severe symptoms. All three of the girls who witnessed the shooting on the bus had PTSD diagnoses. David, who witnessed his sister's death, was so traumatized that he refused to discuss the event. Even Yvonne, who did not know the victim murdered outside her window had considerable traumatic reactions to the event.

Personal relationship to the victim was a powerful mitigating factor for those who witnessed violence acts committed against others. For this reason, the relationship to the victim has been examined as its own category. In combination, the relationship to the victim and the severity of

the trauma seemed to intensify trauma and grief reactions. Witnessing a close friend or family member killed seemed to be the most traumatic event experienced by the youth. This was most evident in the three girls who witnessed the shooting on the bus. Witnessing the murder of someone else, even if they are unknown to witness, also has a traumatizing effect. Yvonne vividly described at the age of eight, watching as a stranger's brains spilled out on the pavement after being shot in the head.

Re-experiencing phenomena of Posttraumatic Stress Disorder seem to be prevalent amongst those who witnessed extreme acts of violence. The subjects, who witnessed violent acts committed to others, described in vivid detail what happened. Most did not report any loss of memory or dissociation. Almost all of the youth described often feeling as if the event just occurred, and recalling every detail and sensation.

Victims: Trauma to Self

Youth who described instances when they were the direct victim of an act of violence reported more sensitivity to the events than to violent events which they witnessed. Several of the youth had been "jumped" which resulted in minor physical violence and theft. However, such a

personal attack had a lasting effect, even for Trevon who had been exposed to an extraordinary amount of violence in his life.

Being threatened with a weapon was identified as a traumatizing experience for three participants. The mortal threat of a weapon had more of a traumatizing affect than the numerous physical fights they reported being involved in. For David, being threatened with a knife pointed at him was the “scariest” event he experienced, even though he had witnessed extremely disturbing acts of violence, such as family members being stabbed and murdered.

A pervasive emotional reaction reported by all direct victims of violence (or those threatened with serious bodily harm) was powerlessness. Raheem described it as he stared down the barrel of the gun pointed in his face, realizing for the first time that he might die. Trevon described it when he was jumped in the same area where he used to rob others, stating: “I do the shit to people…Niggers don’t do this to me.”

The most pervasive and long-lasting symptom reported by direct victims was hyper vigilance. Those respondents who had been physically assaulted or severely threatened reported being more guarded and

watchful afterward. Direct victims reported avoiding places or situations where they might be re-victimized. In contrast, those who witnessed traumatizing events avoided people and places that might remind them of the event or the victim.

Subjective Experience of Severity

Exposure level appeared to influence posttraumatic reactions; however, it was not the only variable. Subjects like Jordan, who did not experience direct traumatization, still met the criteria for Chronic PTSD. In contrast, Miguel, who was actively involved in a considerable amount of community violence, did not meet the criteria for PTSD. Cross-case analysis suggested that there were several factors which influenced the impact of traumatic events. Some of these factors included: severity of trauma; perceived threat; age of trauma; and, relationship to victim.

Witnesses to violence were also affected by their exposure level. The youth who were direct witnesses to their friend's death, reported more traumatic symptoms than those who experienced vicarious tramatization. Similarly, those who were direct victims of violence experienced high levels of distress. However, the subjective severity of traumatic events seemed as powerful a variable as the exposure level. For

example, Cynthia, who was a direct victim of a robbery, did not have as entrenched symptoms as Tonia, who was an eye witness to her friend's shooting.

The severity of traumatic events experienced by each youth was very subjective. One can only speculate as to why certain events were experienced as more severe than others. Several mediating factors were identified, such as: relationship to the victim; level of exposure to the trauma (i.e. witness or direct victim); and, severity of the traumatic event. Age of victimization is another potential mediating factor which may impact the subjective experience of traumatic severity. Several subjects described traumatic events which occurred when they were very young. They described these events with remarkable detail and vividness, suggestive of them being imprinted on their memory. For example, Trevon said that he remembers the shooting of his grandmother as if it happened yesterday, even though it occurred 14 years previously, when he was only four years old.

Ultimately, there was not a definitive causal relationship between exposure level and resulting posttraumatic symptoms. Several additional variables influenced the psychological impact of traumatic events beyond

the objective severity. There were however, clustered similarities among the different levels of violence exposure.

Relationship to Victim

The relationship to the victim appeared to affect the severity and longevity of posttraumatic and grief-related reactions. For purposes of diagnoses, the reactions of grief and PTSD are separated; however, the reality is that they are not as clearly delineated. The youth who had close relationships to victims appeared to suffer from symptoms of grief and loss in addition to posttraumatic reactions. The relationship to the victim also affected the impact of the trauma and resultant PTSD symptoms.

Grief & Loss

The relationship to the victim mediated the severity and duration of grief-related symptoms. Most of the youth interviewed described having lost someone close to them to violence. Relationship to the victim seemed to be as critical a mediator of traumatic reaction as the objective severity of the trauma. Proximity to the traumatic event also had an impact upon subsequent posttraumatic and grief-related symptoms. Several subjects described how their relationship to victims affected them

long after the event occurred, in the form of memories, associations, and felt-experiences.

The different reactions of three girls who witnessed the same shooting on the public bus provide evidence the affect that personal relationship has upon trauma and grief-related reactions. One witness did not know the victim at all, whereas, the other two were close friends of his. The witness who did not know the victim, Jenny, described acute traumatic reactions, such as a vivid recollection of details of the event, and increased arousal and panic when recalling her own experience of being trapped. Jenny did not recall the name of the victim, nor did she discuss her relationship to him. In contrast, the two girls who knew the victim, Tonia and Sarya, spoke at length about the grief and loss they experienced after witnessing their friend killed before their eyes. Directly witnessing the traumatizing event seemed to exacerbate the grief, and vice versa.

Severity of Traumatic Reaction and Relationship to Victim

The degree of subjective intimacy the subject felt towards the victim seemed to be proportionate to the severity of their post-traumatic and grief reactions. This is most evident in the posttraumatic reactions of the two siblings interviewed, Jordan and Tamika. Both had objectively

experienced the same critical events: the deaths and shooting of two cousins, and the threats to their older brother's safety. However, the results of the *Children's PTSD Inventory* (Saigh, 2004) yielded two different diagnoses.

Jordan was diagnosed with Chronic PTSD, whereas Tamika had a negative diagnosis for PTSD. There is no conclusive evidence to explain the differences in diagnoses, as they may be attributed to age, gender, etc. However, during the course of the interview, the most salient feature was the different ways that the two youth talked about their relationships to the victims. Jordan identified his cousin's shooting as the first "scary" thing that happened to him; whereas, Tamika initially did not identify anything, than labeled the threats to her brother as "scary." Jordan described at length how close he was to his cousin. In contrast, Tamika spoke more about her fears that her older brother would be shot by youth in the neighborhood. Once her brother was safe and moved away from the threats of the neighborhood, all of Tamika's anxiety-related symptoms subsided. Most of Jordan's PTSD symptoms continue to this day, as do his symptoms of grief. Although the same objective events occurred to both

youth, their subjective relationship and connection to the victims mitigated their PTSD and grief-related reactions.

The relationship to the victim and the subjective sense of connection, or intimacy, appear to be mediating factors of PTSD reactions; as well as, enduring grief-related symptoms. Based upon the interviews conducted, the longevity of posttraumatic and grief-related symptoms was proportionate to the level of intimacy which existed between the witness and the victim. This appears to be true even incases where the violent act was not even directly witnessed. Several subjects described traumatic reactions related to the sudden death of people close to them without having witnessed the event. Thus, vicarious traumatization seems to be mitigated the most by relationship to the victim.

Diagnoses & Trauma-Related Symptoms

Most of the subjects in this study had a diagnosis of Posttraumatic Stress Disorder following the traumatic events they described. Many had Chronic PTSD with some symptoms which continued to persist years after the trauma. Cross-case analysis indicated that there were some common characteristics of the types of posttraumatic symptoms youth reported. The symptoms reported by several youth also met the criteria for complex

traumatic syndrome. Among the population selected for this study, there was a high rate of trauma-related symptoms ranging from acute PTSD to more chronic and pervasive posttraumatic reactions.

PTSD Diagnoses

Ten of the twelve youth met diagnostic criteria for PTSD. Of the ten youth with PTSD diagnosis, eight had the Chronic Type, while two had Acute PTSD. None of the respondents had delayed onset PTSD. It was difficult at times to make differential diagnoses between acute and chronic PTSD, because some respondents endorsed some symptoms only affecting them for a brief period of time, while other symptoms were present for a prolonged duration. Differential diagnoses were based upon the overall number of symptoms endorsed as being acute or chronic, and their severity.

The assessment instrument used for diagnoses divided symptoms into the three main symptom categories identified in the DSM-IV: re-experiencing; avoidance and numbing; and increased arousal. Features of these symptom clusters which were consistent across cases are described respectively below.

Re-experiencing Symptoms

The most prevalent PTSD symptom cluster endorsed by the subjects interviewed was re-experiencing symptoms. There were common characteristics of the re-experiencing symptoms reported by the subjects interviewed. Many reported often feeling as if the traumatic events just happened yesterday, and most were able to recall the events with vivid detail. Several subjects reported having sleep disturbances and bad dreams, especially immediately following the event. Most subjects reported having images of the traumatic event popping into their mind, especially in the months immediately following the event.

Physiological reactions to reminders of the trauma were experienced by all of the subjects. These included increased heart rate, accelerated breathing, sweaty hands, and stomach aches. These symptoms were experienced in association with a range of trauma-related reminders. Reminders of the traumatic event which triggered physiological symptoms included people and places associated with the trauma. Subjects also reported having physiological symptoms when in situations they perceived as being potentially threatening, such as interpersonal conflict, or being alone in dangerous areas.

Avoidance & Numbing

Cross-case analysis revealed that there were symptoms of avoidance and numbing which were common across the cases. Immediately following the trauma, most of the subjects reported trying to block out thoughts and feelings related to the event. Most subjects also avoided speaking with others about the event. Following a period of acute posttraumatic symptoms, many of the subjects did speak about the event to select people in their lives. Most of the subjects interviewed had vivid memories of the events which occurred; however, three of the twelve subjects did report not remembering certain parts of the event. Most subjects reported avoiding people, places, and things that reminded them of the event. For some, this avoidant tendency persisted for only a few months, for others it persisted for several years.

Several symptoms of avoidance and numbing correlate with symptoms of a depressive episode. These symptoms were less frequent, but considerable among half of the subjects. The symptoms endorsed included avoiding friends and social interactions, loss of interest in previously pleasurable activities, and avoidance of situational reminders of the event.

Under the PTSD criteria of avoidance and numbing are symptoms related to altered perceptions of the future. Most of the subjects interviewed stated that their beliefs about their future changed after the trauma experienced. The most common altered perception of the future was subjects changing their mind about their chances of having a long life. Many youth reported fears that they would die at a young age. This altered perception of the future appeared to be associated with both specific trauma and chronic exposure to community violence. Several subjects said that they realized they could die young after significant people in their lives were killed, or their own lives were threatened. In addition, the cumulative deaths caused by community violence contributed to youths' fears of dying at an early age.

Increased Arousal

The most common symptoms of increased arousal were those related to affect regulation and aggression. Immediately following the traumatic event, most subjects reported getting easily upset, being angry, and frequently getting into verbal or physical fights. In most cases, these symptoms decreased in intensity and frequency over time; however,

many subjects reported that these alterations in mood and affect regulation never completely subsided after the trauma.

Hypervigilance was another very common PTSD symptom associated with increased arousal. Every subject reported being more careful and watchful after experiencing a violence-related trauma. Hypervigilance persisted long after the trauma, and became a regular state of being for most of the subjects. They reported being more aware of the threats surrounding them and more careful and guarded in most situations. Additional symptoms related to increased arousal were difficulties concentrating and sleep disturbances.

Related Symptoms & Diagnoses

In addition to PTSD, several subjects described symptoms which are associated with other diagnoses. This study did not involve a comprehensive clinical assessment; therefore, other diagnoses are not definitive. At least three of the subjects described symptoms often associated with depression. One of the subjects who were not diagnosed with PTSD endorsed several symptoms associated with depression. One subject described symptoms which corresponded to the criteria for generalized anxiety disorder. The youth who were most involved in

violence-related activities described behavior patterns which are often associated with diagnoses of oppositional defiant disorder or conduct disorder. Several male youth regularly used mind altering substances, and may have met criteria for substance dependence.

Complex Posttraumatic Stress Syndrome

As the review of literature on trauma explained, many trauma specialists argue that there are distinctly different trauma-related disorders. These clinical experts have surged for another trauma related diagnosis which has been termed Complex Traumatic Syndrome, or Disorders of Extreme Stress Not Otherwise Specified (DESNOS). The symptoms related to these disorders have been incorporated into the PTSD diagnosis of the DSM-IV, thus combining the two posttraumatic disorders.

In the current study, the assessment instrument used to measure and diagnose posttraumatic reactions was based upon the DSM-IV for Posttraumatic Stress Disorder. However, when analyzing the pattern across multiple cases, it was discovered that many of the common symptoms endorsed by the subjects were those symptoms associated with complex trauma. In addition subjects described related difficulties which

are associated with complex trauma or DENOS. Several subjects met criteria for Disorders of Extreme Stress Not Otherwise Specified. The criteria consist of five symptom areas which will be respectively compared to the qualitative data.

The first criterion for DESNOS is alterations in regulating affective arousal. Many of the subjects interviewed described having difficulties controlling their emotions especially anger; and these difficulties increased after their trauma. Subjects indorsed several of the symptoms associated with these criteria of DESNOS. These symptoms included: chronic affect dysregulation; difficulty modulating anger; self-destructive behavior; and impulsive and risk-taking behaviors.

The second criterion for DESNOS relates to alterations in attention and concentration. The symptoms associated with these criteria are amnesia and dissociation. Only three of the subjects reported not remembering details of their traumatic experiences. However, many subjects reported having difficulties maintaining attention and concentration. They often described having difficulties paying attention in school following their traumatic experiences.

The third diagnostic criterion for DESNOS is somatization. One of the most commonly endorsed symptoms among the subjects interviewed were trauma-related somatic reactions. Most of the subjects interviewed endorsed the physiological symptoms associated with PTSD. These included increased heart rate, difficulty breathing, stomach aches, and sweaty palms.

The fourth criterion for DESNOS is chronic characterological changes. Several of the subjects interviewed described changes which may be considered endemic of these characterological changes. One symptom of this criterion is alterations in self-perception, which includes: chronic guilt or shame; feelings of self-blame, of ineffectiveness, and of being permanently damaged. Both Jordan and Tonia described unrealistic feelings of guilty or responsibly for the deaths of those close to them. David described how he felt “cursed” because he was “bad.”

Chacterological changes also include alterations in relations with others. This includes an inability to trust or maintain relationships with others; as well as, a tendency to be re-victimized and to victimize others. Most of the subjects interviewed described being distrustful and having tumultuous relationships especially after repeated violence exposure.

Many of the subjects described engaging in fights themselves, and lifestyles which involved regular perpetration of violence. Related characterological changes are alterations in perception of the perpetrator. Individuals with DESNOS may adopt distorted beliefs idealize the perpetrator. For some of the youth interviewed—especially those actively involved in violence — there was an idealization of violence and power.

The last criteria for DESNOS are alterations in systems of meaning. These alterations may include despair and hopelessness; or, loss of previously sustaining beliefs. Several of the youth described changes in their systems of meaning, or their views of their own future. For example, many youth believed they would not live long after seeing so much violence in their lives. Some youth seemed to develop very pessimistic or hopeless attitudes about the world and their place in it.

A few of the youth met all of the criteria for DESNOS, especially the youth who had become immersed in violent inner-city lifestyles. Other youth exhibited several of the diagnostic symptoms but not enough to warrant a diagnosis of DESNOS or complex traumatic syndrome. However, many of the symptoms endorsed by the youth on the PTSD Inventory correlated with those which comprise DESNOS. Symptoms of

DESNOS which seemed most prevalent amongst the youth interviewed in this study were those related to alterations in regulating affective arousal and somatization. Symptoms related to chronic characterological changes and alterations in systems of meaning were also quite common among the respondents.

Dynamics of Violence

Violence was a predominant aspect in the lives of all of the youth interviewed. All of the youth said that they had difficulty managing their anger and have been in fights with other youth. Many indicated that they had more difficulty controlling their tempers after experiencing a traumatic event.

Affective Dysregulation

All of the youth interviewed mentioned having difficulties managing their affect, especially anger. Many were very sensitive and emotionally reactive. Several stated that their anger management difficulties began after the traumatic incidents they experienced. Immediately following the trauma, many youth described feeling irritable, hypersensitive, guarded, and confrontational. The affective reactions described by many of the youth fit the description of affective

dysregulation. Affective dysregulation is the term used to describe a severe and persistent inability to control one's mood states. Children with affective dysregulation have an impaired ability to filter and process the sensory information presented to them. Affective dysregulation is often accompanied by explosive and unpredictable episodes of out of control behavior. The subjects interviewed described varying degrees of these symptoms. All of them struggled with managing their affect, especially their anger.

Aggression

One of the most commonly endorsed symptoms of significant distress following trauma were engagement in arguments and fights with classmates, teachers, and family members. For some, these aggressive tendencies subsided over time. All of the students reported that they continue to have difficulties controlling their temper. Sarya said that she had trouble with her anger ever since witnessing her friend's murder. Yvonne described her own hypersensitivity as becoming very easily irritated by others. Even Trevon, who initially claimed not to be affected by his chronic exposure to violence, was extremely restless during the

interview and he laughed nervously as he described shocking acts of violence.

Based upon cross-case analysis, the subjects who recovered from their trauma actively applied personal coping strategies for managing their aggressive thoughts and feelings. Consequently, they described engaging in less physical violence over time. High risk youth demonstrated less insight into their own aggression and behavior. The youth who continued to engage in committing violence expressed less concern about managing their anger and affect. These youth described numerous accounts of community violence which they actively engaged in. For these youth, the trauma caused by community violence exposure led to an increase in violent behavior.

Trauma caused by community violence appeared to provoke internal distress and anger in most of the youth. However, resilient youth managed this internal distress and their externalization of aggression decreased over time. The traumatic event helped them to avoid violent altercations. In contrast, the youth who were at higher risk had less insight and maladaptive means of coping with their anger. They tended to

externalize their internal state of anger. As a result, these youth described an increase in aggressive behavior following trauma.

Code of Conduct within Urban Youth Subculture

Youth described a certain code of behavior pertaining to violence which is prevalent among inner-city youth. Interpersonal violence is the means by which most conflicts are dealt with. Both male and female subjects described fighting as a common occurrence in their lives. Avoiding physical confrontation was often viewed as cowardice and weakness. Subjects described how fights were often provoked and encouraged by other youth. Many subjects described how fights erupted as a result of “petty” incidents, such as one boy talking to another boy’s girlfriend, or one girl giving another girl a “nasty” look. Some of these “petty” fights escalated into fatal violence.

Loyalty to peers was another code of behavior pertaining to youth violence. When fights occurred, peers were expected to join in to protect their friends. As Trevon aptly described it, his friends were like brothers, and he had to back them up during a fight, or they would “beat his ass.” Thus, even if a youth wanted to avoid violence, he was enlisted to fight by association. Trevon wanted to avoid violence and crime because he did

not want to violate his parole and be sent back to jail. However, when his friends got involved in a fight, he felt a loyalty to join them, despite the risks. As a result of this code of loyalty and protection, fights between two individuals often escalated to large scale gang-type fights.

Masculine Roles among Urban Youth

There were gender role expectations pertaining to youth violence. Both males and females engaged in physical fights. However, males tended to get into more frequent and severe fights. All of the weapon-related violent events described were committed by male youth. Several subjects described how boys were expected to fight and even admired for it. Some youth even described instances when girls expected boys to fight for them. For many inner-city youth, fighting was the way that males gained respect. When Trevon dealt drugs, he described, "beating crackhead's asses" so that they would respect him and not consider robbing him.

Fear was not an acceptable emotion for inner-city males. During the interview, several male subjects initially conveyed a tough thug persona; and, stated that they had never experienced a "scary" event, although they endorsed an extraordinary number of PTSD symptoms. As the

interviews progressed, male subjects allowed themselves to be more vulnerable. Trevon, who initially stated that his chronic exposure to violence did not affect him, later confessed, “I am scared all the time.” Thus, inner-city male youth felt the need to consistently present an external persona of toughness to ward off threat and to garner respect from other youth.

Socio-Economic Inequities and Related Hostility & Despair

Many youth identified socio-economic inequalities as factors contributing to youth violence. Poverty was a justification for theft, robbery, and assault for several of the high risk male subjects. Raheem justified robbing people because, “You have to eat.” Similarly, Trevon antagonistically asked the interviewer, “Well you can be some rich ass therapist but we over here-we over here hungry – feel me?” Lower socio-economic status appeared to make some youth feel entitled to take what they could from others, regardless of the cost or harm inflicted. There was however a continuum of self-righteous entitlement. Trevon laughed as he indicated that the handheld digital music player he was holding was not his, implying that he stole it. On the other hand, Raheem tried desperately

not to harm anyone, and tried to behave more like "Robin hood…stealing only from the rich to feed the poor."

Socio-economic inequities appeared to evoke a certain level of hostility in most of the subjects. For high risk youth, it justified their own criminal behavior. For other youth, the pervasive poverty and lack of opportunities led to resignation. According to Tonia and Yvonne, youth violence was primarily caused by the multitude of problems inner-city youth endured combined with the lack of opportunities and positive outlets available to them. As Tonia stated,

> Cause a lot of the people that I know, they all live in projects or poverty and they felt like they ain't got no way out…. Like nobody trying to help them up. Seems like everybody just trying to bring them down.

Surrounded by devastating poverty, many inner-city youth develop narrow views of their own opportunities and future. The oppression of poverty, violence, and few positive opportunities contribute to a pessimistic, hostile perspective. Several youth confessed having a foreshortened view of their future; recognizing the realistic possibility that they may die at a young age. Consequently, many of the high risk youth lacked a sense of delayed gratification; and instead, focused on satisfying their needs and wants immediately. There was an attitude among several

youth which involved getting what they could by whatever means necessary. At first glance, their amoral behavior and values could be considered antisocial. However, for several youth their behavior was an understandable response to the oppression and inequality they experienced on a daily basis. Additionally, their Machiavellian value-system was often normalized by the mores of the surrounding inner-city.

Risk Factors

There were several risk factors which emerged during the interviews with the youth in this study. Some risk factors were self identified by the subjects. Other risk factors were interpreted by the researcher based upon the effect they had upon the youth's life. Risk factors consisted of individual, social, or environmental factors which were detrimental to healthy and adaptive development. These factors were associated with negative, deleterious outcomes, such as: increased violence exposure and perpetration; delinquency; social problems; and maladaptive personality development.

High Violence Environment

The predominant risk factor for all of the youth interviewed was the high rates of community violence which they were pervasively

exposed to. Their neighborhood and school environments were arenas where there was a constant threat of violence. Many of the subjects interviewed were random victims of the traumatic violence they experienced. The girls who witnessed their friend shot on the bus had nothing to do with the preceding events which lead to the shooting. David had little control over the violent acts committed against his siblings. Jordan and Tamika were not even present when their cousin was shot. Thus, the environments where these youth spent the majority of their time were the greatest risk factor for exposure to community violence.

Negative Peer Affiliation

There were also those subjects who placed themselves at more risk by being actively involved in the violent youth subculture. These youth were not always innocent bystanders of community violence; but rather, were actively involved in committing acts of violence themselves. These youth were at even higher risk of repeated exposure to violence, and had a higher chance of being more severely victimized. Involvement with peers who engaged in violence appeared to increase risk exponentially. Thus, the high violence environments increased these youths' chances of engaging in more violent activity; and subsequently, becoming

traumatized victims. Trevon and Raheem both described several large scale fights they were involved in as both perpetrators and victims of the violence.

Criminal Activity

Involvement in illegal activities placed youth at greater risk for several negative outcomes. Two youth described their involvement in illegal activities, specifically dealing drugs. They described how dealing drugs placed them at higher risk of violence and/or arrest by law enforcement. Raheem confessed to having a gun when he dealt drugs, whereas Trevon described protecting "his corner." At the time of the interview, both youth had already served sentences at juvenile detention facilities. Brandon had also been in a juvenile detention facility for fighting. Thus, three of the four youth who were actively involved in community violence already had criminal records and had served time in juvenile facilities.

Substance Abuse

The high risk youth described using drugs to cope with their negative affective states and posttraumatic reactions. Both Trevon and Miguel said that smoking marijuana helped them deal with the anger and

distress they felt in reaction to their exposure to violence. They said that it helped them to relax and forget about their problems. Raheem also alluded to use of marijuana to cope with negative affective states.

The potential for abuse of drugs and alcohol was high with several of the youth interviewed. The high risk youth seemed to have used it as a means of avoiding painful emotions, especially those related to trauma. Continued use of mind altering substances to avoid facing posttraumatic reactions can often lead towards substance abuse and dependence. Additionally, drug use is often associated with violent behavior, thus increasing the risk of these youth becoming involved in more community violence. Finally, the illegality of street drugs places the youth who use them and/or deal them at high risk of being involved with the juvenile justice system. This was the case for several of the youth who admitted their involvement with illegal drugs.

Family Conflict

Incidents of domestic violence were disclosed by three of the subjects. Several other subjects described conflicts that they got into with their parents. At the age of four, Trevon witnessed his grandmother get shot accidentally by his uncle during a family dispute. Cynthia disclosed

that her older brother had hit her and her mother. Raheem described being "beaten" by his mother as a child. These childhood events seemed to have a lasting affect. Trevon stated that he can remember the shooting of his grandmother as if it happened yesterday. Cynthia continues to be distressed by the control her older brother exercises over her family. Interviews revealed that family violence and conflict me be a precursor to later traumatic responses, and also may make it more difficult for youth to rely upon their parents for emotional support.

School Difficulties

Most of the youth interviewed described experiencing academic difficulties following traumatic events. Symptoms included difficulty concentrating, decreased motivation, and restlessness. Several subjects indicated that their grades dropped after experiencing a particularly traumatizing event.

Academic difficulties also seemed to coincide with an increase in risk-taking behaviors. Trevon described having behavior problems in school, and then eventually dropping out to spend time with his friends who no longer attended school.

Protective Factors

All of the youth interviewed were able to identify at least one supportive relationship which helped them to cope with adversity. For many it was family; but for others, it was adult confidants and peers. Community organizations were also identified as valuable support systems. In general, the youth who appeared to be most engaged with supportive social systems had better prognoses for positive outcomes.

Family

Family was the predominant source of support identified by subjects. However, there were varying degrees to which youth shared their experiences with their parents. As a result, some subjects received immediate support in coping with their traumatic experiences, while others, who did not share details of violent experiences, only received peripheral support from their family. Most subjects identified their mothers as the primary support figure in their family. Extended family members were also a significant source of support for many of the youth.

Family members provided traumatized youth with a range of different types of support. Subjects identified family members as a source of emotional support for coping with immediate crises. Jordan and

Tamika described how their mother was there for them to talk to when they felt sad after their cousin's death; or, how she helped them feel safe when their brother's life was being threatened. Parents helped victims to feel physically and emotionally safe; and, they aided them in processing their feelings and resolving their loss.

Several youth described how family members helped them to deal with grief and loss by fostering spiritual beliefs and understanding. Parents provided youth with a broader, faith-based means of understanding and coping with overwhelming events and related emotions. David described how his mother helped him to go from feeling like he was cursed and wanted to die, to feeling hopeful and good about himself. He attributed this personal transformation to "God and mom."

There were some youth who were not as intimate with their family, and who did not divulge the traumatizing events they experienced. Although most participants identified their family as a primary source of support, several said that their parents were unaware of their most traumatizing experiences. There appeared to be multiple reasons why subjects did not share their experiences with their family. One reason was becomes they did not want their family to worry about their safety.

Raheem said that he did not want to worry his mother by telling her about his traumatic experiences, such as his life being threatened at gun point. Another reason alluded to was that parents were unaware of the risks their children were placing themselves in; and, if they knew the dangers, they would limit their freedom. Cynthia indicated that she hid most of the details of her personal life from her family, because "they don't understand." A related reason was that some youth felt ashamed of the life of risk and violence they were so involved in. Trevon's family had very little knowledge of the gang fights he was frequently involved in. He added that he felt that he had let his parents down by getting arrested.

Adult Confidants

There were significant adults in the lives of several youth who provided support which was not always accessible from family members. Many of the youth identified the directors of the violence prevention program as the principle adults with whom they shared details about their personal lives. James described the unique relationship many of the youth felt towards the director of the violence prevention program. He said the director, Rudy, was the person he came to talk to about things related to life on the streets, because he had been there and he understood

what it was like. James added that although he loved his Mom and she was very supportive of him, she did not know what it was really like. For Cynthia, who felt very distanced from her own family, the youth program directors were "like family;" and, she said that she talked to them more about what was happening in her life than she did with her own parents.

There were several factors identified that fostered rapport between key adult figures and the youth. A critical factor in the rapport youth developed with staff was that they could talk from direct experience and empathize with the struggles youth were having. Several subjects stated that the program director, Rudy, knew what it was like to be involved in youth violence; he had been where they are and he had learned how to rise above it. Another factor which seemed to strengthen rapport was the mutual respect which existed between staff and youth. The youth were considered equal and active members of the program. Finally, youth described a sense of belonging and trust that they felt towards the adults, often referring to the group as their "family."

Peer Support & Intimate Partners

Peer relationships were instrumental in helping youth work through post trauma emotions. Many youth said that initially they did not speak to anyone after the traumatic events they experienced. The more traumatizing the event, the more some youth isolated themselves. However, after an initial period of isolation, many youth opened up to friends and classmates. Processing shared traumatic experiences was identified by many of the youth as being critical in their recovery from trauma.

The youth who witnessed the shooting of their classmate said that immediately following the incident, they were annoyed by people constantly asking them about it. Tonia described not speaking to anyone at all for a month after the event. Sarya was angry and isolated herself. Gradually these youth began to talk to friends and teachers. The victims said that talking about what happened was very difficult and upsetting at first, but that they also found relief in expressing their feelings to peers. The youth in the violence prevention program said identified sharing their painful, violence-related experiences in a group forum as one of the most helpful aspects of the program. Peer support and sharing aspects of

trauma and grief-related experiences were identified by many subjects as being very helpful once they overcame the initial posttraumatic impulse to isolate and block out thoughts and feelings related to the event.

Community Resources: School & Community-Based Programs

School and community-based programs were the most common community resource identified by the youth. The violence prevention program which the majority of the subjects participated in was identified by several youth as being instrumental in helping them to cope with youth violence. Subjects described specific attributes of the program which were most helpful. Several youth said that the sense of belonging they experienced was like being part of a "family." The leaders of the program, who had established strong rapport and trust with the youth, were viewed as key sources of support. The program also allowed youth to travel to different areas of the country and talk with other students about ways to prevent youth violence. These opportunities for experiences beyond their everyday environment were considered very important by several youth. Sharing experiences was also identified as being helpful for overcoming the pain and grief associated with being victims of community violence. Based upon the youths' reports, the common

characteristics of an effective youth program were: caring leaders who could empathize with members, opportunities to share experiences with peers, and a sense of purpose and efficacy.

Mental Health Professionals

Two of the subjects interviewed disclosed that they were receiving regular psychotherapy from a mental health professional. The two subjects in psychotherapy, David and Sarya, both indicated that therapy has helped them in many ways. They both said that their therapist helped them deal with the overwhelming feelings associated with their traumatic experiences. David said that he is able to talk about the traumatizing incidents he suffered, such as the murder of his sister. David refused to discuss the death of his sister during the course of the interview, and also stated that he does not talk to other people about it. The exceptions are his mother and his counselor, whom he does talk to about the horrible events he witnessed. Sarya said that therapy helped her deal with the initial trauma after witnessing her friend's shooting. Now, she says that her therapist helps her to better manage her anger and upsetting feelings. Although only two of the twelve subjects identified mental health

professionals as a source of support, the support provided seemed significant in the healing process.

Resiliency

Resiliency was the category used for personal qualities or strategies which youth employed to help them cope with adversity and trauma. For the purposes of categorizing qualitative data, resiliency was reserved for coping strategies which were more intrinsic and relied less upon interpersonal relationships and external resources, which were categorized as protective factors. Youth identified certain ways of coping which relied primarily upon their own internal processes rather than external interactions with others. Resiliency also referred to personal qualities which youth identified as aiding them in dealing with adversity in their lives.

Creative Expression

More than half of the youth identified creative expression as an important means of coping with difficult experiences as an adolescent. Writing was the predominant media; specifically, in the form of poetry and journal writing. Drawing and art were also identified by one subject as a helpful form of self expression. Creative expression served many

purposes. For four of the subjects (Yvonne, Tonia, Sarya, and David) writing helped them to process feelings of grief and loss following the sudden deaths of close friends and family members. Yvonne described how she used writing as a method of managing her emotions, especially her anger; and as a result, she has been involved in less conflict and fights with others. Miguel described how drawing helped him to calm down when he felt angry and upset; he became absorbed in the process of drawing and gradually forgot about what was bothering him.

Creativity seemed to be a means by which youth tried to cope with overwhelming emotions and experiences; and, attempted to find meaning or a way to express themselves. During the interview subjects were asked how they got through such difficult experiences. Spontaneously, several youth said that one way they got through their pain was writing. Creative expression seemed to provide an outlet for youth who may not have felt willing or able to verbal express their feelings to another person. Creative expression also helped traumatized youth grapple with more profound, even existential, issues, such as, why their close friend or family member was suddenly and brutally murdered. Creativity seemed to be a critical

component of the process of making meaning of the trauma and tragedy experienced.

Self-Esteem & Positive Life Choices

There were certain personality characteristics which were associated with more resilient tendencies among the youth. Self-esteem and a sense of self-efficacy were common traits among those youth who appeared to cope more effectively with trauma. These traits also corresponded with youth making more adaptive and positive life choices. The youth who said that they felt good about themselves and their lives were more likely to have positive perspectives for the future. The youth who were more actively involved in violent lifestyles reported more maladaptive behaviors and more negative world view.

Trevon indicated that dropping out of school was one of the mistakes he made in his past. He also stated that he gained respect from others by the material possessions he attained from money made as a drug dealer. Raheem described feeling bad about himself after robbing people, especially when he had to physically hurt them. David felt that he was "cursed" as a result of the bad things he did.

Youth who felt that they could affect change, especially in regards to youth violence, appeared to cope better with trauma and violence than those youth who felt that powerless over the violence around them. Youth who presented limited or no recommendations for resolving youth violence, tended to resort to physical violence during most conflicts. Thus, self efficacy seemed to influence both recovery following trauma, and flexibility in dealing with conflicts.

Making Meaning

Many of the youth underwent a period of searching for meaning in relation to their overwhelming traumatic experiences. Youth tried to understand why such painful events happened to them or their loved ones. During this process of searching, many found solace in spiritual beliefs. Many also made decisions to change the way they led their own lives.

Trauma as Catalyst for Change and Positive Growth

An unexpected finding in this study was the role that trauma had in promoting positive change in the lives of the youth interviewed. Many of the youth said that they did not regret having experienced such traumatic events, because the incidents made them examine their own

lives. Tonia said that watching her friend get shot taught made her grow up. She realized that the "petty stuff" she used to fight over was not worth it. Many had witnessed how a simple disagreement could escalate quickly into a shooting. Most of the subjects said that the violence-related trauma they experienced forced them to realize the life-threatening risks associated with conflict and fighting. For Yvonne, the violent deaths of people close to her, taught her to avoid people and places which may place her at risk. She expressed her conviction to pursue a positive future for herself, rather than succumb to the destructive lifestyles of many other youth. Subjects said that they learned to appreciate life more after experiencing how easily and permanently it could be taken away.

Traumatic events which were personally meaningful, and often most distressing, were the incidents that functioned as a catalyst for change. The subjects who most clearly and convincingly described making positive changes in their lives were able to distinctly describe the event which caused the change. When asked to share a "scary" or traumatizing event, the pivotal event was always the first one identified. The subjects were also able to describe the critical event with vivid clarity. Raheem described that moment for him, when he stared down the barrel of a gun

pointed two inches away from his left eye. He had experienced numerous objectively traumatizing events such as: being stabbed, witnessing shootings, and involvement in deadly gang fights. But none of those incidents were as traumatizing as that specific incident when he was threatened with a gun. Thus, the critical incident in subjects' lives was subjectively meaningful, rather than objectively the most severe.

Spirituality & Fate

Youth who experienced positive growth following trauma tended to grapple with existential questions about life. There was a common propensity to expand upon the limitations of their own traumatic experience to gain deeper understanding. This process of searching for understanding was spiritual in nature for many of the youth. These youth were inclined to reframe tragic or painful experiences into something positive and meaningful. Tonia, for example, described God must have had better things planned for her friend who was killed. Yvonne and other subjects described how each person "has their time to go." These spiritual beliefs seemed to help youth cope with their loss. Their existential or spiritual belief systems gave them a way to reconcile the senseless deaths of people close to them.

Spiritual beliefs were also an impetus for more positive and altruistic behaviors. Several youth alluded to their own spiritual beliefs as their source of values that guided their judgment and behavior. David described how “God and mom” helped him to be “good.” David also attributed the horrendous trauma he experienced to being “cursed” and “bad.” Thus, he held a strong belief in a judgmental god who rewarded the righteous and punished the “bad.” Raheem described his faith in god as a source of strength in his life which helped him make the right choices. Therefore, spirituality both provided youth with faith to cope with their overwhelming experiences; and it helped guide their behavior.

Causes of Youth Violence

The youth interviewed speculated that the causes of youth violence ranged from petty conflicts which escalated to more psychological problems such as low self-esteem and negative life circumstances. Some youth alluded to poverty and social inequities as the reason for violence and crime. Most of the youth had negative attitudes towards violence, especially those who had been most harmed by its effects.

Negative Life Circumstances and Poor Self-Concept

Negative life circumstances and a poor self-concept were the most common explanation for youth violence. Subjects believed that the youth who committed violent acts were often faced with many problems in their lives and felt negatively about themselves. Yvonne identified a range of problems violent youth might be dealing with, such as: family problems, school difficulties, and conflict with peers. She felt that violent youth are "brought down" by multiple forces until the only option they think they have is to act out violently. Tonia had a similar perspective, suggesting that violent youth usually feel bad about themselves and so they want to make another person feel bad also.

Peer Conflicts

Conflicts among youth were regarded as another one of the main causes for youth violence. Several subjects described scenarios in which two people had a minor disagreement which escalated into physical violence. Most youth felt that violence resulted from "petty" disagreements and minor insults, rather than more justifiable offenses. Examples of the causes for conflict and potential violence between youth were: fights over boyfriends and girlfriends, verbal slights, peer

affiliations (e.g., gang affiliation), and territorial disputes. Most of the acts of community violence witnessed by the subjects were the result of minor disagreements. In many cases, the victims of violence were innocent bystanders; and in some cases, they were trying to mediate the disagreement and were shot accidentally.

Weapons

Guns were identified as a leading cause for youth violence, especially pertaining to the number of people killed by community violence. Many youth described how easy it was to get a gun; some even said they could get one immediately if they wanted. The threat of guns made conflicts between youth more deadly. Some subjects described how fighting without guns was more respectable. Trevon said that in his neighborhood people fought all the time, but guns were never allowed. There was an understanding in his violence-riddled neighborhood that you could fight out your differences, but not pull out a gun. Tonia had a similar sentiment, suggesting that boys who used guns were cowards and they should be able to fight like a man rather than shoot a gun. To many of the youth, guns were the reason that youth violence had become so

devastating. Jordan’s one wish was that all the guns in the world would be taken away.

Recommendations

Some of the youth in this study had definitive and well-conceived recommendations for dealing with the various problems associated with community violence. Other youth were less optimistic and felt that it would always exist and that there was no realistic solution for it. Most of the suggestions provided by the youth related to improving conditions for youth rather than controlling violence. Violence was often viewed as a symptom of more entrenched problems. Solutions recommended by the youth centered around empowering youth to make healthier choices and providing them with positive, self-affirming opportunities.

Increased Youth Programs

Programs for youth were the most common recommendation for dealing with the problems of youth violence. Youth identified several attributes of youth programs which they felt help them deal with community violence and make positive choices in their lives. Youth programs provided a supportive community of peers and trusting adults who youth could turn to when they had problems. They were places

where youth felt safe from the neighborhood violence. Programs provided youth with opportunities to engage in positive recreational activities they liked to do such as: sports, dance, and other enrichment activities. Subjects also described how youth programs provided functional support such as job opportunities and academic help. In summary, participants seemed to indicate that youth programs provided them with a place where people made them feel safe, productive, and good about themselves.

Opportunities

Positive opportunities for lower income inner-city youth were identified as a potential solution to youth violence. These opportunities included: increased youth programs; sports; employment; and exposure to other cultures and communities. Several youth described how urban youth have very few positive outlets, and as a result engage in detrimental activities. These youth often have limited resources, as do their schools and communities. As Yvonne described it, the youth who are violent have been brought down by a lot of things in their lives, and they act out. Therefore, opportunities to participate in programs and activities which fostered positive self-esteem and accomplishment were sited as one of the best solutions to youth violence.

Additional Themes and Patterns of Qualitative Data

The qualitative data gathered from the subjects yielded additional results which were not contained within the broader general categories. Cross-case analysis revealed consistent patterns which deserve mention. One noticeable pattern was the relative consistency of gender differences. Another notable variable was the effect age had in subjects' capacity to process traumatic experiences.

Gender Differences

There appeared to be consistent differences between the ways that males and females processed traumatic experiences and utilized social support systems. Female subjects appeared more capable than male subjects of mobilizing social support systems to help them cope with traumatic experiences. Female subjects were able to share their feelings more easily with peers than male subjects. Several male subjects said that they did not talk to anyone about traumatic events they experienced. The male subjects suggested that it would be viewed as a sign of weakness to talk to male peers about their victimization and related fears and posttraumatic symptoms.

Some male subjects identified select individuals whom they shared their experiences with and relied upon for support. Male subjects indicated that intimate partners were a source of social support. Trevon said that he talked to his girlfriend about the violent experiences he struggled with. Miguel also identified his girlfriend as the person whom he talked to about upsetting feelings and experiences. The female subjects seemed to have a larger, more accessible support network. It also seemed more acceptable for them to express feelings of loss, pain, and fear. Male subjects had less socially acceptable opportunities to process their feelings. It was more acceptable for males to express anger in the form of violent acting out, than to be vulnerable and share feelings of loss and fear.

Age Differences

Age seemed to affect youths' capacity to process traumatic experiences and the type of coping mechanisms they had at their disposal. Younger youth seemed to experience less efficacy in their ability to actively cope with their traumatic experiences. Their coping strategies were naïve (e.g., Jordan hiding under the covers when scared), and their solutions tended to be simplistic (e.g., getting rid of all the guns). In contrast, several of the older youth engaged in a deep search for meaning

and understanding following their traumatic events. Several of the older youth found ways to transform their painful experiences into stories of empowerment and help other victims of violent crime. Younger victims tended to have an external locus of control; i.e., they believe that they were passive recipients to what was done to them by the outside world. Older victims, especially those who were more resilient, appeared to have an internal locus of control; and therefore, believed that they were active co-creators of their own fate.

Cultural Factors

Culture appeared to have a meaningful influence upon the youth interviewed. Although the sample size was too small and heterogeneous to make significant inferences, there were notable cultural factors which were mentioned by several of the youth. Cultural values appeared to influence several domains in the youths' lives, including: family practices, support systems, and spiritual beliefs.

Cynthia described how her Chinese culture impacted family functioning and caused conflict between her and her parents. She described the difference between the expectations of Chinese culture and the developmental tasks of independence among American teenagers.

Cynthia said that she does not tell her parents anything about her personal life, including the times that she has been exposed to violence, because "they would not understand." She also says that her cultural values prevent her family from seeking help. Her brother's abusive dominance over the family is tolerated because her family would never tolerate the public shame of admitting such behavior is occurring in their home. Consequently, Cynthia says that she cannot wait to go to college and get away from her family. However, she also struggles with feelings of obligation to her mother and is reluctant to leave.

Raheem describes the family practices and network of support common among the Polynesian community. As he said, laughing, "There ain't no such thing as child abuse in the Polynesian community." He described corporal punishment which would be considered child abuse by American standards. He also explained the loyalty which family have to each other. Raheem described several incidents when his brothers and cousins protected each other during episodes of large scale neighborhood violence.

David's story depicts the violence and trauma which many recent immigrants endured who seek refuge from their oppressive countries of

origin. David had witnessed several incidents of violence while living in the Philippines; as well as, numerous natural disasters. David also conveyed the deep spiritual beliefs of his culture. He connected his own tragic experiences to being "cursed." His recent improvements in behavior and emotional state were attributed to "God and Mom."

Cultural variables influenced the youth of this study in several domains of their lives. The risk factors they were exposed to were often related in some way to their socio-economic situation. Family structure and functioning were within the broader context of culture. The quality and type of social support available to the youth was greatly determined by cultural factors. Finally, the internal models for coping with adversity were strongly influenced by cultural traditions and mores.

Integrated Analysis and Emergent Theory

A comprehensive analysis of the cross-case themes revealed potential patterns of youth development in response to community violence. The youth who appeared to adjust and recover from their violence-related traumas described common themes. Similarly, there were common themes among those youth who had an overall worse prognosis for a myriad of risk factors including: violence-related trauma, personal

involvement in violence, and criminal activities. A holistic examination of the totality of data derived from the interviews suggested two trajectories of personal and social development in response to community violence. One trajectory was in the direction of resilience and recovery from trauma. The other trajectory led towards a cycle of complex trauma and increased involvement in violence and other detrimental risks. Based upon the qualitative data, there were pivotal experiences which influenced the direction of either trajectory for each youth. These pivotal experiences were influenced by several factors, including: pre-trauma environmental factors; trauma-related specifics; internal response of the individual; and the interaction with the broader social community.

Pathways of Resiliency & Risk in Response to Community Violence

This section will propose a theory of youth development in the context of community violence. Table 5: *Pathways of Resilience & Risk in Response to Community Violence*, presents this theory in visual form. Stages are presented which relate to the interaction between community violence and the personal development of the youth. At each stage, tasks have been identified corresponding to the two trajectories of development in response to community violence.

The processes of risk and resiliency proposed are not mutually exclusive. Youth may experience aspects of either process in the course of their development following trauma. Even amongst the most at risk youth, there were strengths and positive values. Many of these youth did report having their own value systems. There were also individuals who had previously been very engaged in violence and crime, who then made a conscious effort to change in later adolescence. Similarly, youth who eventually recovered from their trauma described periods of aggression, hypervigilance, and depression. The pathways of risk and resiliency presented are trajectories based upon common attributes and experiences described by the subjects.

Table 5: Pathways of Resilience & Risk in Response to Community Violence

Development & Community Violence	*Pathway of Resiliency: Recovery & Positive Growth*	*Pathway of Risk: Complex Trauma & Violence*
Stage I: Violence Exposure	Protective Factors	Risk Factors
	• Close Support System • Safer Environment • Positive Behaviors	• Few intimate Resources • Chronic Violence • Previous Trauma • Risk-Taking Behavior
Stage II: Critical Incident	Distress & Loss	Numbing & Anger
	• Acute PTSD & Grief • Life Changing Event • Immediate Safety	• Avoidance of Support • Numbing of Affect • Anger

Stage III: Internal Response	Personal Meaning & Faith	Hopelessness & Self-Preservation
	• Spirituality & Existential Searching • Increased Morality • Positive Reframing	• Emotional Dysregulation • Self-destructiveness • Negative Self-concept • Truncated Morality
Stage IV: Social Interaction	Reaching Out	Isolation & Negative Peer Affiliation
	• Vulnerability • Sharing Emotions • Positive Peer Group • Adult Confidants • Empathy & Altruism	• Emotional Isolation • Hypervigilance • Deviant Peer Group • Delinquency & Crime
Stage V: Future Orientation	Perseverance & Community	Resignation & Violence Perpetuation
	• Optimistic future • Emphasis on success • Community Involvement • Hope	• Violence Perpetration • Academic/Job Failure • Few Opportunities • Negative View of Future • Despair

Stage I: Chronic Violence Exposure

There is a broad range of the type, frequency, and severity of community violence which inner-city youth are exposed to. However, the results of this study strongly suggest that community violence is a chronic threat rather than an a few isolated incidents. This chronic exposure to community violence appears to affect individuals in different ways depending upon several variables. The results also suggest that there are both protective and risk factors which may determine the impact of community violence exposure.

Protective Factors

There were several protective factors identified by the youth which may have minimized the effects of community violence. These included family support in the form of safety, protection, and the capacity to share feelings and concerns. Adult supervision also appeared to be a protective factor which reduced the risk of violence exposure. Youth who were involved in positive activities such as school or youth programs were also better equipped to deal with the violence they were exposed to. Many of the youth identified their youth programs as places where they could talk

about their experiences with violence and find mutual support from peers and staff.

Risk Factors

There were several risk factors which placed youth at greater risk of experiencing violence and exacerbated the effects of exposure. Previous exposure to violence, especially at younger ages, appeared to place individuals at greater risk for future exposure and increased susceptibility to posttraumatic symptoms. Family discord and conflict were also risk factors, and often prevented youth from having familial resources for coping with violence related experiences. Academic and behavioral difficulties placed youth at greater risk. Truancy and criminal activity increased violence exposure risk, as did affiliation with peers involved in such activities. The risk factors identified by the youth appeared to both increase the chances of being subjected to violence as well as limit the resources for coping with the physical and emotional effects.

Stage II: Critical Incident

Every youth in this study was able to identify at least one incident which was more traumatizing or threatening than the multitude of violence-related events they had experienced. These critical incidents

often resulted in posttraumatic stress reactions. For several of the youth, the critical incident also marked a turning point in their lives. The emotional upheaval of the traumatic event caused them to re-examine their own lives and often led towards positive personal growth. Those youth appeared to recover from their trauma and make a more adaptive shift in their development all stated that their painful, critical experience was ultimately beneficial to them. In contrast, the youth who continued to be at risk for future involvement in violence, did not identify any positive outcomes of their traumatic experiences. For these youth, the traumatic events they experienced only appeared to exacerbate complex traumatic symptoms and violence-related behaviors. The qualities of critical incidents which led towards recovery and resiliency are described below, followed by the characteristic responses to trauma of youth who had more negative outcomes.

Distress & Loss

Positive growth following trauma appeared to be associated with high levels of distress immediately following the incident. Youth with the most intense trauma and grief related symptoms were also the individuals who described the most post trauma change. Individuals who witnessed

someone killed, especially with whom they had a close relationship, explained how the event changed them permanently. As did the youth who felt that their lives were being seriously threatened. The critical incident which led towards personal change was subjectively the most distressing to the individual, rather than necessarily the most severe by objective standards. Thus the critical incident and subsequent change were highly subjective and personal to the individual.

In addition to distressful levels of posttraumatic symptoms, witnesses to violence also reported significant grief and loss. Youth with a strong relationship to the victim tended to have more intense and longer periods of grief. As with trauma, those who experienced the most distress also reported the most significant changes.

Numbing &Anger

The youth who did not portray positive growth following trauma reported described psycho-physiological reactions which are associated with complex traumatic reactions. These youth reported less severe distress in response to the critical incidents identified. Most of the at-risk youth tended to block out feelings and not risk the vulnerability to share their emotions. They did not share the traumatic experience with others,

especially not family members. Outwardly, these youth presented with a tough, invincible demeanor, stating that violent experiences affected them very little. However, based upon their PTSD inventory, most of these youth had clinically significant PTSD symptoms. Anger was the most common reaction these youth had to both their own victimization and harm inflicted upon people close to them. Consequently, their behavioral reaction to most of their traumatic experiences was increased arousal symptoms in the form of hypervigilance and aggression.

Stage III: Internal Response

Following critical incidents of violence, youth reported a period during which they tried to find meaning related to the event. This was especially true for the youth who were resilient and tended to recover better from the event. Resilient youth found ways to salvage some positive personal meaning from the trauma. In contrast, the youth who were at more risk tended to view the event as evidence that their world was a hostile place and they must be prepared to defend themselves.

Personal Meaning

All of the youth who experienced positive growth following trauma described a period of working through their pain and fear to find some meaning or purpose in the experience. For some, creative expression helped them in this working through phase. For others it was the faith or belief system of parents or other supportive adults. These youth engaged in a form of existential searching to understand why such an unfortunate tragedy happened to them, or to someone close to them.

Resilient youth also described how the critical event which occurred caused them to change perspectives on their own lives and future. Many youth described how they realized how fragile life can be, and how easily it can be taken away. A common theme amongst resilient youth was transformation towards nonviolence. Following the death of someone close, or threat to their own life, these youth realized how potentially fatal any conflict can become. As a result, many youth made conscious efforts to manage their own anger and avoid fights. In the process of recovering from their trauma, resilient youth became more mature, and positively future oriented.

Hopelessness& Self-Preservation

Youth who did not struggle with finding personal meaning to the traumatic events they experienced, continued to engage in violence, and tended to have less positive future orientations. The youth most involved in violence appeared the most apathetic to its effects. They did not come to the realization that their behavior was self-destructive. Rather, they described how they retaliated in response to their victimization. Many of these youth described how they became excited in anticipation of a fight. Violence had become a source of power for these youth; a way to combat the powerlessness they may have experienced as a victim.

Based upon their statements and behaviors, at-risk youth appeared to be more amoral than the resilient youth. They reported criminal activities and the perpetration of violence with very little remorse. Youth reported assaults, robberies, and narcotics trafficking as common activities. The remorse reported often related to being apprehended, rather than concern about the victims. The youth at-risk for violence portrayed a degree of cold self-protection. Their value system also seemed to be based on getting what they could, by any means necessary. For

some, there was a focus on material gain, regardless of whose expense it was attained.

Stage IV: Social Interaction

In concert with forming personal internal values related to violence, youth from the two different paths exhibited divergent social patterns. Youth who recovered from their trauma and were more resilient sought adaptive peer relationships and attempted to effect positive solutions to youth violence. The at-risk youth gravitated towards other youth who had similar interests in deviant behaviors. These youth described patterns of social interaction fraught with conflict, defiance, and aggression.

Reaching Out

A common social trend among the resilient youth was reaching out to others for support in order to cope with trauma-related difficulties. Individuals who were resilient identified significant sources of social support in their lives which they could rely upon immediately after their trauma. Initially many of the youth reported avoidance symptoms of blocking out feelings and not talking to others about the event. However, resilient youth tended to open up to others after a short period of time.

Thus, initial isolation was gradually overcome and individuals were able to share their feelings with others.

Resilient youth described consistent, trustworthy sources of social support in their lives. They found relief in the support of peers, family members, and adult confidants. Every resilient youth was able to identify at least one significant individual in their lives with whom they could share their more private thoughts and feelings. For some, these were family members, or peers. Others, who were less connected to their family, found intimate support in adult confidents such as the leaders of their youth program, therapists, or teachers.

Isolation & Negative Peer Affiliation

At risk youth tended to be more emotionally isolated and affiliate with other youth who engaged in self-destructive activities. These youth tended to report that they told no one about their traumatic experiences. They also did not have significant people in their lives that they trusted enough to share their innermost feelings, especially emotions which may reveal vulnerability or weakness. These youth presented with an impervious armor of toughness despite underlying posttraumatic

symptoms. Most of these youth had to ignore their own emotional reactions to being victims of violence. During the interview process, the youth who presented as being the toughest, least scared of violence, were the individuals who spoke incessantly for hours once they trusted the interviewer. These youth seemed to have no healthy outlet for their accumulated fear, anxiety and loss.

There appeared to be a negative social progression for those youth most at-risk whereby their interactions with peers and society became increasingly detrimental and self-destructive. Some of the signs of this progression were: school failure and drop out; criminal involvement; poverty; and negative peer affiliation. Most of the youth who perpetrated violence frequently attended school if at all, had already been incarcerated, and came from neighborhoods and families of extreme poverty. These youth also reported having friends with similar histories. These youth sought belonging as do any youth; however, they found it among peers who were equally involved in destructive lifestyles. As a result, their most influential source of social support was also their greatest source of risk for future involvement in violence and crime.

Stage V: Future Orientation

There was a distinct difference between the perspectives of the future formed by resilient youth versus those at high risk. The resilient youth tended to be more optimistic and view their future as an opportunity to grow, despite their painful experiences. Youth who were at higher risk tended to maintain a view that the future only held more of the same threat and suffering they had endured. Whereas resilient youth tended to be excited about the unknown possibilities which lay in the future; at-risk youth were guarded and pessimistic about the unexpected threats that the future may entail.

Perseverance & Community

Resilient youth presented with perseverance to overcome the obstacles of their environment and self-confidence to attain positive life goals. Most of them did not regret the painful experiences they endured because they felt these pivotal events had helped them focus on having a more meaningful life. Many of these youth also described becoming part of a broader community devoted to affecting positive change. They were involved in programs which advocated for youth and attempted to ameliorate youth violence. Resilient youth managed to transform their

traumatic experiences into lessons to teach other youth. Common characteristics of these exhibited were self-esteem, efficacy, and a mature level of self-awareness. They conveyed a desire to promote positive change in their communities and overcome adversity rather than succumb to its perils.

Resignation & Perpetuation of Violence

The at-risk youth tended to be reactionary to their environment and were more pessimistic about their own future than their resilient peers. They had few recommendations for dealing with youth violence and tended to retaliate with violence whenever threatened. Some of the youth even admitted to being the provocateurs of violence. These youth did not convey a sense of genuine self-esteem or a healthy sense of self-efficacy. Several youth said that they feared they would die at a young age. At risk youth tended not to have the optimistic plans for their future that the resilient youth had. Many had stopped attending school and were already involved in crime. Their orientation tended to be with the thrills and material gains of the present rather than striving towards more adaptive future goals.

Several of the at-risk youth viewed violence as one of their only sources of power. They garnered respect by the fear they could instill in others. These youth tended not to have other healthy sources of self-esteem. Money from criminal activities provided a false sense of success, but also increased their involvement in violence. These youth described how they had to fight or carry a gun to protect their territory when dealing drugs. Crime often led to incarceration, which in turn resulted in more involvement with violence. Thus, youth become engaged in a viscous cycle whereby they become deeper entrenched in self-destructive behaviors and violence with fewer opportunities to escape.

CHAPTER SIX: DISCUSSION

This study examined the effects of community violence on inner-city youth, with special attention to trauma and resiliency related processes. A mixed-methods design was used consisting of quantitative analysis of standardized assessment instruments and qualitative analysis of interviews conducted with youth exposed to community violence. There were four topics which were studied in relation to the central research question. The first area was the level of community violence subjects were exposed to. The second was traumatic responses to violence exposure. The third area explored were the resilient factors youth employed to cope with the trauma and adversity related to community violence. Finally, the interaction between community violence and processes of risk and resiliency were evaluated.

With respect to the first area of inquiry, the results indicate that inner-city youth are exposed to an extraordinarily high level of community violence compared to average American youth. Subjects were given the *Exposure to Community Violence Survey* (Richters & Martinez, 1998), which assess the frequency of witnessing, and/or being a victim of, various forms of community violence. Although the current study did not

have a large enough sample size to yield statistically significant findings, it is notable that the rate of violence exposure was similar to larger, statistically valid studies. In the current study, 50% of the youth interviewed had witnessed a shooting or stabbing. Other empirical studies found that 40-60% of inner-city youth had witnessed someone shot or stabbed (Bell & Jenkins, 1993; Kotulak, 1990).

The second area of inquiry pertained to the posttraumatic symptoms experienced by youth exposed to community violence. A standardized assessment instrument, The Children's PTSD Inventory (Saigh, 2004), was used to identify PTSD symptoms and formulate diagnoses based upon DSM-IV criteria. The results indicated that ten of the twelve subjects (84%) had diagnoses of PTSD following traumatic experiences caused by community violence. Of those diagnosed, eight were diagnosed with Chronic PTSD, and two with Acute PTSD. The association between community violence and PTSD is comparable to the findings of similar studies (Fitzpatrick & Boltizar, 1993; Jaycox et al., 2002; Martinez & Richters, 1993). This study also found that re-experiencing symptoms were the most common type of PTSD reaction in response to community violence. The results of this study also support the assertion

that PTSD is very prevalent among inner-city youth and often remains undiagnosed and under treated (Martinez & Richters, 1993).

Disturbances of physiological and affective regulation were very common amongst the youth interviewed. This corresponds to assertion that trauma is a psycho-physiological disorder which wreaks havoc on both the body and mind (van der Kolk, 1996). Research on the physiological aspects of trauma corresponds to the symptoms described by the subjects. Loss of stimulus discrimination led to hypervigilance and increased arousal symptoms. Increased "fight or flight" reactions produced by damage to the amygdala explain affective dysregulation and increased aggression among the youth. The interpersonal nature of community violence may contribute to disruptions in healthy attachment, and explain why so many of the youth had difficulty trusting others, and experienced tumultuous relationships.

This study also found that there were several factors which influenced the severity of PTSD reactions to trauma. One factor was the proximity and severity of the violence, which corresponds to previous studies on youth exposure to violence (Pynoos & Eth, 1985). Youth who were directly victimized tended to exhibit more severe symptoms than

those further removed from the violence. In addition, the severity of the perceived threat had an impact upon posttraumatic reactions. Another factor affecting posttraumatic reaction was the relationship to the victim. The findings from this study are similar to related studies which found that interpersonal attachment was positively correlated with severity of posttraumatic symptoms (Pynoos et al., 1987).

Analysis of posttraumatic symptoms and qualitative data indicated that several subjects met criteria for Complex Traumatic Syndrome (Herman, 1992) or Disorders of Extreme Stress Not Otherwise Specified (van der Kolk, 1996). Subjects endorsed common symptoms and personality traits associated with these disorders. Symptoms included difficulty regulating affect, aggression, and somatization. Characterological changes included alterations in self concept and relation to others. Subjects also described alterations in their systems of meaning. These symptoms associated with complex trauma tend to include chronic personality changes and more entrenched maladaptive behaviors.

Posttraumatic aggression was a common experience for the youth in this study; however, the external manifestation of aggressive behaviors varied broadly. The more resilient youth developed coping strategies to

resolve their internal distress. The violence-related trauma they experienced often led to a decrease in personal involvement in physically violent situations. However, high risk youth appeared to lack the insight and coping resources to manage their aggressive affect adaptively. Consequently, these youth described increased perpetration of community violence. Thus, violence related trauma triggered anger in most of the subjects; however, resilient youth discovered adaptive means of processing their aggression. In contrast, high risk youth externalized their internal distress in the form of violence and other acting out behaviors such as substance abuse and crime.

The risk factors identified in this study correlated with those found in previous studies on risks associated with community violence. These included: family conflict; early childhood trauma; affiliation with delinquent peers; academic failure; delinquency and criminal activity. The youth at highest risk were also the ones most involved in violence related activities, and who were categorized as both victims and perpetrators of violence. These youth exhibited many of the qualities Parson (1994) attributes to Urban Violence Traumatic Response Syndrome, including:

truncated moral development; damaged self-concept; and re-victimization.

The causes for youth violence proposed by some of the youth were very insightful. Several youth believed that youth violence was ultimately caused by youth being “brought down” by a multitude of external and internal forces. These included forces of oppression such as limited opportunities, poverty, and school and family problems. Social factors included conflict and jealousy associated with other youth. Individual factors contributing to violence were low self-esteem, depression, and anger. As one youth described it, violent youth get brought down so low that all they can do is violently act out. This complex perspective on youth violence echoes the words of Wilson (1990) who was quoted previously:

> …as a result of the underdeveloped power of the African American community, the violent subduing of others may often be their only significant achievement and ‘claim to fame.’ Their capacity to perpetuate violence is the great equalizer in a world characterized by great inequalities (p. xvii).

This study also found promising results related to positive growth following trauma and adversity. Many of the youth interviewed described how their traumatic experience eventually led towards personal growth and positive changes in behavior. This finding is consistent with the

research on adversarial growth (Updegraff & Marshall, 2005; Linley & Joseph, 2004). This study found similar qualities associated with positive growth as those identified in previous studies. Subjects who experienced a high level of subjective distress following trauma, were most likely to report positive growth following trauma. Additionally, youth who had spiritual convictions, or who underwent a period of existential searching, experienced growth and optimism.

Adaptive coping and adversarial growth were enhanced by certain resilient qualities identified by the youth. The more resilient youth tended to convey more optimism and self efficacy pertaining to their lives and futures. This finding is consistent with similar results that youth with situational and constitutional optimism were more likely to report adversarial growth (Updegraff & Marshall, 2005). Resiliency was more prevalent among those youth who had an internal locus of control. Youth who felt that they influenced their environment (i.e., internal locus of control) were more resilient than youth who felt that they were shaped and controlled by the external environment (i.e., external locus of control).

Creative expression was a predominant coping method for fostering resiliency which has received little attention in the research on

community violence. Over half of the subjects described creative expression as a way that they dealt with painful feelings and even managed disturbing affective responses. This self-initiated coping strategy implemented by the youth corresponds to the limited research on arts-based interventions being applied to the treatment of trauma (Malchiodi, 2003b).

The protective factors found in this study corresponded with those identified in similar studies. Subjects described family as being a primary source of support in their lives. However, adult confidants, such as youth program staff, were identified as sources of support which youth often preferred over family members because of their similar life experiences and rapport. This finding relates to Fosha's (2003) assertion that a caring adult, who possesses a high reflective self function, can enhance the resilience of an individual. Peers and intimate partners were identified as positive sources of social support. Other protective factors identified by the subjects in this study were community resources such as youth and school-based programs.

Several recommendations were suggested as ways to deal with the problems of youth and community violence; however, most youth did not

feel that there was a definitive solution for this epidemic. Opportunities for underprivileged youth were sited as a way to combat the hopelessness which often fueled youth violence. There were several types of opportunities which subjects thought would be empowering. These included increased programs for youth, such as sports and enrichment programs. Employment opportunities were sighted as an alternative to engaging in illegal activities such as dealing drugs. Youth programs which specifically dealt with violence prevention were also sited as important means of reducing community violence.

Process-oriented analysis of the results led toward the development of an emergent theory for the developmental processes of risk and resiliency in relation to community violence. This theory suggests that there are two distinct development trajectories for young victims of community violence: (a) the developmental path of resilience and recovery; and, (b) the development of complex trauma and immersion into a violent lifestyle. Qualitative data analysis of individual case studies and cross-case comparisons revealed key factors which comprised each of these pathways.

Resilient youth who recovered from trauma were more distraught and affected by the critical traumatic incident in their lives. These critical incidents were often a catalyst for personal change and spiritual inquiry. Resilient youth risked being vulnerable and sharing emotions with others; whereas, their high risk counterparts tended to exhibit more symptoms of complex trauma such as: affective dysregulation, emotional numbing, and avoidance of talking to others about their experiences. Finally, youth who were more resilient exhibited empathy and altruism, returning to their community to empower others so that they may overcome adversity. In contrast, high risk youth displayed comparatively truncated moral development and they continued down a progressively self-destructive and violent pathway.

Clinical Implications

The results of this study present several implications for clinical practice with inner-city youth. This section will present data from the study which may impact clinical practice and suggest interventions which may best meet the unique needs of this population. Relevant clinical literature pertaining to specific intervention strategies and treatment recommendations will also be presented.

Many of the youth in this study alluded to socio-cultural inequalities which contributed to the viscous cycle of violence and trauma among inner-city youth. As with the sample in this study, most inner-city youth affected by community violence are people of color. Consequently, culturally competent counseling with urban minorities should be considered fundamental to working with this population.

Harris (1998) presents a model for counseling disadvantaged African-American males, which takes into account the masculine norms of inner-city males. Many inner-city youth accept and prefer the urban, "street-wise" masculine norms and hold these as greater worth than more traditional masculine characteristics of their own culture or mainstream European American culture. Consequently, Harris (1998) warns that confrontation of these inner-city masculine norms can lead to defensiveness and feelings of alienation. She recommends allowing adolescents to set the pace of exploring these values without intervening until the youth's level of insight has been determined.

Minority adolescent females face dual oppression of racism and sexism. These perceptions linked to gender, race, and socioeconomic status can ultimately lead to feelings of powerlessness among female

adolescents of color (Fordham, 1993). Holcomb-McCoy & Moore Thomas (2001) advocate that therapists promote a sense of self-efficacy despite the oppressive factors which may impact these youth.

Joining inner-city minority youth in a non-judgmental manner can decrease defensiveness and increase rapport. Aiding them in navigating their own youth culture and empowering them to make healthy choices can ultimately foster healthy development without fears of rejection.

The prevalence and severity of posttraumatic symptoms indicate a need for increased efforts in the areas of assessment. The results of this study mirror similar studies which found that a shockingly high number of youth with PTSD as a result of community violence remain undiagnosed and untreated (Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001). Trauma and violence experts recommend more comprehensive assessment and screening for youth in inner-city schools.

Comprehensive assessment is crucial for differential diagnosis of the range of psychiatric disorders which may result from chronic violence and trauma. This study supports the assertion of other trauma experts that there are distinct trauma-related disorders which differ in their etiology and amelioration to treatment (Herman, 1992; van der Kolk, 1996). Many

of the youth in this study met criteria for both Posttraumatic Stress Disorder, as well as Complex Trauma Syndrome. In order to properly diagnose and treat inner-city youth affected by violence, it is essential that a comprehensive assessment is conducted with assessment instruments that discriminate between the different trauma-related disorders.

Comprehensive assessment with traumatized youth is also warranted due to the frequency of co-morbid psychiatric disorders in addition to PTSD, including: depression, substance abuse, conduct disorder, and Attention-Deficit Hyperactivity Disorder (ADHD). Several of the subjects in this study identified symptoms which correlate with diagnostic criteria of additional disorders, especially depression and oppositional defiant disorder. Early and comprehensive assessment of at-risk inner city youth is necessary in order to insure that these youth receive appropriate services before their condition deteriorates in the direction of more complex traumatic reactions and increased risk.

This study indicates that the reactions of youth to violence related trauma often changes over time; therefore, so should the treatment approaches. Several youth identified a period of avoidance prior to openly coping with their trauma. Thus, clinicians should allow traumatized youth

to set the pace of dealing with their traumatic experiences. This is similar to Herman's (1992) warning that traumatized clients have often experienced powerlessness and lack of control; therefore, in the therapeutic setting, they should be given the power to determine the rate at which they reveal traumatic material.

The sequella of PTSD related symptoms described by the youth in this study can inform clinicians working with other inner-city youth who have suffered from violence-related trauma. The youth in this study reported a prevalence of re-experiencing related symptoms, especially intrusive thoughts and images as well as physiological responses to traumatic reminders. Cognitive behavioral strategies such as relaxation techniques and exposure therapy have proven effective for reducing re-experiencing symptoms among traumatized youth (Cohen, 1999).

Several traumatized youth described disruptions in physiological and affective regulation following traumatic events. Many of these youth indicated that creative-arts based activities such as writing helped them to manage these overwhelming thoughts and emotions. Expressive arts-based therapies including creative writing, dance, drama and visual art have proven effective with trauma victims (Malchiodi, 2003a). Therapeutic

approaches which work with visual images, such as art therapy, can help youth work through intrusive images of the trauma (Steele, 2003; Johnson, 1987; Pynoos & Eth, 1985). Integrated visual art and collaborative story-telling has helped traumatized inner-city youth uncover and work through trauma within a structured creative format (Avidar, 2003). Trauma intervention groups for children that involved art therapy techniques and cognitive therapy demonstrated reduction in all three DSM-IV subcategories of PTSD (Steele, 2003).

Experiential and body-oriented therapies have proven effective for helping victims reclaim their body and work through physiological posttraumatic reactions (Meyer, 1998). Drama therapy can be instrumental in helping victims of interpersonal violence resolve their trauma; and, has been used effectively with traumatized adolescent girls (Carbonell & Parteleno-Barehmi, 1999). Fosha (2003) describes the advantages of utilizing experiential therapies in treating the overwhelming affective and physiological responses to trauma:

> Therapies that deal with disorder that are fundamentally emotional in nature need to be able to reliably access sensory, motoric, and somatic experiences to engage them in a dyadic process of affect regulation and eventual transformation. This requires the bottom-up processing approach of experiential therapies, rather than the

> top-down approach of most cognitive and insight-oriented therapies (p. 229)

The results of this study also suggest that many youth may suffer from more pervasive posttraumatic reactions such as those described in the diagnoses of Complex Traumatic Stress Disorder or Disorders of Extreme Stress Not Otherwise Specified (DESNOS). Youth who may exhibit symptoms of Oppositional Defiant Disorder or Conduct Disorder, may in fact, be exhibiting the characterological alterations typical of complex trauma. Complex trauma often involves more in-depth and longer psychotherapy treatment. Herman (1992) has identified three phases to long term trauma treatment: (a) safety; (b) remembrance and mourning; and, (c) reconnection. Treatment for complex trauma must not only address the explicit posttraumatic symptoms such as affect dysregulation and hypervigilance, but also the alterations in self-concept, systems of meaning, and relating to others.

The youth who seemed at highest risk in this study, were often those who did not share their traumatic experiences with others. Therapeutically working through the traumatic event itself is a central goal for most trauma-focused therapies regardless of the theoretical orientation. Gradually focusing attention upon the actual trauma can help

integrate the experience into a more adaptive narrative experience. Besides clinicians, family members and adult confidants can be invaluable support systems with whom youth can allow themselves to feel vulnerable and eventually share their painful experiences.

Adolescents rely upon peers for an enormous amount of social support, and this resource should be harnessed during the recovery process. Several youth in this study identified peers as critical in helping them overcome trauma and grief reactions. Among adolescents traumatized by community violence, group therapy has reduced PTSD symptoms, complicated grief symptoms, and improved academic performance (Saltzman et al., 2001). Group therapy has also significantly reduced re-experiencing and avoidance symptoms within the PTSD spectrum (Shalloum, Avery, & McClain, 2001). For victims of interpersonal violence, trauma-focused group therapy can normalize traumatic reactions, help process emotional reactions such as anger, and foster healthier relationships with others (Herman, 1992).

This study illustrated how prevalent aggression is among inner-city youth and it can become an entrenched component of their daily lives. Therapists need to have sophisticated and compassionate understanding

of the role aggression plays in the development of urban youth. Aggression may serve a self-protective function for traumatized youth who are reminded daily of potential threats to their safety. Grief and loss can also manifest as anger and hostility. Violent behavior can also be a form of retaliating against oppressive forces of racism, poverty, and economic inequalities. Therapists working with this population should not reactively quell anger; but instead explore the underlying meaning it holds and attempt to find healthier outlets for its expression.

Working with inner-city youth traumatized by violence can trigger intense emotions for both the therapist and client. Parson (1994) cautions about transference and countertransference reactions which can often emerge in the therapeutic relationship with this specific group. One common countertransference reaction is what he terms, the "minimizing response," in which the therapist views violence as "normal for urban kids." This countertransference reaction may be caused by being overwhelmed by children's stories of trauma, or therapists having difficulty dealing with their own aggression. The "avoidance/fear" response is often due to fear of reliving the child's traumatic past via intense re-experiencing symptoms. As a result of this countertransference

reaction, therapists are unable to model necessary courage and confidence to tolerate the child's trauma.

The "pitied child" countertransference reaction occurs when the therapist identifies with the helpless aspects of the child's experience and may fail to recognize and identify the child's strengths and potential resiliency. "Passionate parenting" is found in therapists who want to "right all the wrongs" suffered by the child. This reaction is caused by an unconscious desire to fulfill all the child's dependency needs at a cost of getting to know the child's own reality and true self.

Therapists working with inner-city youth need to explore their own assumptions about this population and continuously examine emotional reactions which may emerge. Urban youth have developed their own methods of navigating the dangerous terrain of the inner-city, and can prove to be the best resource for realistic solutions. Whenever possible, therapy with adolescents should be a collaborative endeavor, rather than the common dichotomy which exists between "child" and "adult."

The youth in this study revealed an unexpected and surprising aspect of trauma which often goes unaddressed by clinicians; that trauma can led to positive growth and change. This is one of the most clinically

meaningful findings of this study. Clinicians often focus upon the negative effects of trauma, aiming to help their clients put their painful experiences in the past. However, traumatic events can prove to be a turning point for some youth. This finding is supported by other studies documenting positive growth following a range of traumatic experiences including community violence exposure (Linley & Joseph, 2004; Updegraff & Marshall, 2005). In the aftermath of trauma, clinicians can support clients in finding meaning to the experience; or assist them in making positive, healthy choices for their own futures.

There are several key clinical implications of this study and related research findings. First, there is a predominance of youth with PTSD as a result of community violence, who remain undiagnosed and untreated. Secondly, therapeutic interventions should match the types of symptoms the client is experiencing. Thirdly, intact social support systems should be integrated into treatment to maximize recovery and reconnection. Fourthly, clinicians should be wary of high-risk, aggressive youth because they may suffer from complex trauma. The fifth point is that therapists need to be cognizant of their own emotional reactions which may be triggered while working with such an intense client population. Finally,

traumatic experiences may ultimately prove to be catalysts for positive change and should be explored and encouraged in the course of therapy.

Recommendations for Future Research

The research conducted for this study was exploratory in nature; as a result, there were certain limitations. The sample size was too small to permit statistical analysis; therefore, quantitative results were illustrative and informed qualitative data rather than being independent, statistically significant results. The study sample was also heterogeneous in regards to age, gender, and ethnicity. This yielded a broad range of qualitative data; however, this also made conclusions pertaining to these variables less conclusive. Expanding the sample size would increase validity of quantitative findings; as well as, provide more depth to the qualitative data.

The findings of this study point towards areas where additional research would be beneficial. The standardized assessments conducted indicated a high prevalence of violence exposure and PTSD among this population. Continued research to determine the factors contributing to violence exposure and vulnerability to posttraumatic reactions is warranted. Trauma-related symptoms identified in this study suggest that

many urban youth may suffer from complex trauma as a result of their chronic exposure to community violence. Further research to determine the prevalence of complex trauma would be very useful and could inform the treatment approaches used with this unique population of trauma survivors.

Inner-city youth are surrounded by an extraordinary amount of violence on a daily basis. This chronic exposure often results in violence becoming a common aspect of inner-city life. Many of the subjects in the current study were both victims and perpetrators of violence. Almost all of the youth admitted to having difficulties managing their anger and aggression. Further research examining the psycho-social bases of youth violence would be very beneficial towards ameliorating this devastating social problem.

Despite the prevalence of community violence exposure and trauma among inner-city youth, there has been scant research on effective treatment approaches with this population. Clinical research on strengths-based interventions which focus upon the growth potential following trauma would have important clinical implications. The results of this study highlight the potential benefits of arts-based therapeutic

interventions with this population. Research examining the application of different expressive arts modalities to treat trauma-related symptoms would provide important clinical information.

The results of this study also reveal the effectiveness of group and community-based intervention approaches. Many of the youth studied indicated that their involvement in extracurricular programs — especially those aimed at empowering youth — have been instrumental in their capacity to overcome trauma and succeed. Additional research on the specific benefits of these intervention modalities would be useful for clinical practice and future youth program development.

This study yielded potentially intriguing results in the areas of trauma and resiliency among inner-city youth. More comprehensive research is required in order to better understand the complexities of trauma and resiliency related processes among inner-city youth. Better understanding of these processes can inform more effective, culturally relevant intervention strategies.

Conclusion

At first glance to the reader, the research topic of this study may conjure thoughts of bleak hopelessness. Youth violence has spread across urban areas of America like an epidemic. The prevalence and severity of its impact remains shocking. It is almost unfathomable that 75% of the youth in a given school or neighborhood would have already seen someone shot or killed.

After hearing their stories, the tough, distrusting demeanor of inner city youth is completely understandable; as is their Machiavellian attitude to take whatever they can, despite the risks or costs. What is extraordinary about these youth is their hopefulness and appreciation of the preciousness of life. Enduring war-like conditions have left emotional scars on many youth, but many have transformed as a result of the healing process. If all of the youth from this study could distill one lesson to be shared with the outside world, I believe it would be this: "Don't give up on us."

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APPENDIX A: PARENT & PARTICIPANT CONSENT FORMS

Participant and Parental Consent Form for

Doctoral Study Research Project

Research Project: Trauma & Resiliency among Youth Exposed to Community Violence
Researcher: Mark Purcell, M.Ed, M.A.
(Doctoral Candidate in Clinical Psychology at CIIS)

Mark Purcell, a doctoral candidate at the California Institute for Integral Studies in San Francisco, is conducting a study to examine the risk and protective factors among youth exposed to community violence, or who live in violent neighborhoods.

Participation involves a series of assessment questionnaires and an audio taped interview totaling about 2 hours. The first part of the interview will consist of structured assessment questionnaires. You will be asked about any frightening experiences you may have witnessed or experienced and how they affected you. You will also be asked about the general types of violence you have witnessed in your neighborhood and schools. During the second part of the interview, you will be invited to talk more openly about ways that violence in your neighborhood has affected you, and how you have learned to deal with it.

The interview process may touch sensitive areas for some people; some people may have painful or upsetting memories of violence they have witnessed or experienced. The interviewer will use the utmost professional sensitivity to these matters. You will be free to refuse to answer any question or to end your participation in the study at any time. Mark Purcell will be available before, during, or after the interviewing process to answer any of your (or your parents') concerns, and to facilitate referrals to supervisors, consultants, or therapists if such a need arises. Mark Purcell will also coordinate support with the mental health specialist at the San Francisco Boys and Girls Club if the need arises. Mark Purcell can be contacted at (415) 571-7189.

All information you contribute will be held in strict confidence, and will not be shared with anyone else, within the limits of the law (see attached confidentiality statement). The audio tapes, transcripts, and questionnaires will be kept in a locked cabinet to which only Mark Purcell will have access. Tapes and transcripts will be identified by numbers only. All identifying data will be deleted when direct quotes are used in the dissertation. Access to the tapes will be limited to Mark Purcell and the transcriber. The transcripts will only be shared with you and possibly one

additional co-researcher as a validity and reliability check of Mark Purcell's analysis of the data. Neither your name, nor any other identifying information will be included in the dissertation itself. You may request to omit from the dissertation particular details that you specify to the researcher. <u>All transcripts and/or audio tapes will be destroyed within five years of collection.</u>

A stipend will be provided to participants in the study. No other direct benefit is offered or guaranteed. You may however, find the process helpful and interesting. The information you provide will benefit the understanding of the affects community violence has upon youth and possibly inform more effective ways of supporting them.

If you have questions or concerns regarding you (or your parents') rights as a participant in this research, or if you feel that you have been placed at risk, you may report them – anonymously, if you wish – to the Chair, Human Research Review Committee, California Institute of Integral Studies, 1453 Mission Street, San Francisco, CA 94103, telephone (415) 575-6100.

Participant Consent

I,__________________________________, consent to participate in the study of youth exposed to community violence conducted by Mark Purcell of the California Institute of Integral Studies. I have received a copy of this consent form and the Confidentiality Statement, and I understand that my confidentiality will be protected with in the limits of the law.

____

Signature Date

Parent/Guardian Consent

I,__________________________________, consent to having my child, ______________________, participate in the study of youth exposed to community violence conducted by Mark Purcell of the California Institute of Integral Studies. I have received a copy of this consent form and the Confidentiality Statement, and I understand that my child's confidentiality will be protected with in the limits of the law.

____

Signature Date

If you would like to receive a written summary of the results of the study, please provide an address where it can be sent to you.

Thank You for Your Cooperation and Contribution.

APPENDIX B: SEMI-STUCTURED INTERVIEW

Interview Questions

Resiliency Focused:

You have described some difficult experiences you have had. How do you think you got through them? What are some ways that you have learned to cope with what has happened to you? (Be as specific as possible)

Trauma Focused:

Can you describe aspects of what has happened to you that still bother you? Are there certain memories or experiences that are harder to forget or get rid of than others?

World View Focused:

How do think these experiences changed your life? How did you think or feel before these experiences happened and how do you think or feel differently now. If you could change anything that has happened in your life, what would you change? Are you hopeful for your future?

Open-Ended:

APPENDIX C: SAMPLE INTERVIEW TRANSCRIPT

Mark Purcell: So unless I think you're going to hurt yourself or someone else I will not share anything we're talking about okay and you don't even need to tell me your whole name. If you can--just give me your initials that would help.
YVONNE: H-J-J.
MP: H--?
YVONNE: No, H-J-J.
MP: H-J-J, and what--what's--what name do you say you go by?
MP: Okay; I just have some quick questions--and how old are you?
YVONNE: Fifteen.
MP: Okay; and ethnicity is African American?
YVONNE: Uh-huh.
MP: Okay; and who do you live with?
YVONNE: My mother and my twin brother.
MP: Oh you have a twin brother, okay. And can you tell me what neighborhood--you don't have to give me an address or anything?
YVONNE: I stay in Sunnyvale.
MP: Sunnyvale, okay; okay--so the first thing I'm going to do is run down kind of this rating thing of violence in your neighborhood. Now so not [never, once, or twice]--the times have you heard guns being shot?
YVONNE: Many times.
MP: Seen somebody arrested?
YVONNE: Yeah; many times.
MP: Okay; seen drug deals?
YVONNE: Many times.
MP: Seen someone getting beaten up?
YVONNE: A few times.
MP: Okay; had your house been broken into?
YVONNE: Once.
MP: Have you seen somebody get stabbed?
YVONNE: No.
MP: No; okay, how about shot?
YVONNE: Yes.
MP: A few times?
YVONNE: A few times.
MP: Have you seen a gun in your home?
YVONNE: Nope--never.
MP: How about alcohol--beer, wine in your home?
YVONNE: Wine.
MP: Once or twice?
YVONNE: A few times.
MP: Seen gangs in your neighborhood?
YVONNE: Yeah.

MP: Many times?
YVONNE: Yeah.
MP: See somebody pull a gun on another person?
YVONNE: Few times.
MP: All right; the last one--have you ever seen somebody in your home get shot or stabbed?
YVONNE: Never.
MP: Okay; that is that. The next one--make sure I get all these straightened out. I'll put that over there and I think we're good. Now this one I'm going to ask you about sort of scary things that have happened to you. It could be all different kinds of things that kids go through--they've seen a shooting, hurt by a grownup, whatever, you know something that's been really scary to you at any point in your life. And then I'm going to ask questions about how it affected you, okay; so has there been something really scary that's happened to you--and it can be more than one? We can go through--
YVONNE: I've seen when I was eight--I've seen somebody get shot in the--dead smack in the middle of their head outside in the middle of my street and his brains just rolled down the hill.
MP: Oh my God.
YVONNE: Other than that--
MP: That was the scariest thing that you've ever seen?
YVONNE: Yeah.
MP: Yeah; that's pretty scary. You saw him get shot?
YVONNE: Yeah.
MP: And you saw his brain?
YVONNE: Yeah.
MP: Okay; that's scary enough for one--when you were eight, so what year would that have been? I can figure it out?
YVONNE: Ninety--eighty-something.
MP: Eighty-something okay; we'll figure that out. Any other scary thing happen to you?
YVONNE: No.
MP: That comes to mind--that's the scariest, okay?
YVONNE: Yeah.
MP: How about have you seen any very scary thing happen to someone else?
YVONNE: I seen somebody been robbed before.
MP: Uh-huh.
YVONNE: And then beat up.
MP: And that was the scariest thing you saw someone--happen to someone else?
YVONNE: Yeah.
MP: Okay; when do you think that happened about?
YVONNE: Because all them people been taking people's iPods and phones and everything.
MP: Recently?

YVONNE: Yeah.
MP: Yeah; that happened--Tierra lost her iPod I got her for Christmas that way. She got jumped. When did you see that happen--recently?
YVONNE: Last week.
MP: Last week; that's pretty recent--somebody getting jumped and beaten up?
YVONNE: Yeah.
MP: Girl--boy?
YVONNE: A boy.
MP: In your neighborhood?
YVONNE: I work down there on the [inaudible], yeah.
MP: Okay; and like I said--I also don't need names of anybody and stuff that you saw or anything like that. So no worry about police or anything like that--any--see anything else very scary happen to someone else?
YVONNE: Uh-um.
MP: Okay; so I think the scariest is probably the guy getting shot, right when you were eight?
YVONNE: Yeah.
MP: So I want you to try to think back to when you were eight and how it affected you. Were you very scared when it happened?
YVONNE: Yeah; I even feel sick coming inside.
MP: Okay; and you were very upset when it happened?
YVONNE: Well I didn't--I think I was in shock.
MP: Shock? Did you feel you didn't do anything to stop it, like there was nothing you could do about it, right?
YVONNE: No.
MP: After that happened did you--do you remember moving around a lot or talking a lot--more than usual?
YVONNE: No; I was just quiet is all.
MP: Quiet--okay; after that happened did you have upsetting thoughts about what happened? Did you remember it; did it pop into your head?
YVONNE: Like sometimes when I went to sleep like I'd dream I was like--I'd get it for like two months. I had to sit there and think about it--and then I forgot about it.
MP: Okay; and it just stopped?
YVONNE: Yeah; it just went away, yeah.
MP: Wow; and so did pictures keep popping into your head?
YVONNE: Uh-um.
MP: Then they did?
YVONNE: Oh yeah.
MP: But then it stopped after two months you said?
YVONNE: Yeah.
MP: Okay; so after two months it didn't really happen as much anymore?
YVONNE: Yeah; like I just forgot about it.

MP: Okay; when you were that age do you remember playing games or drawing pictures that was about that?
YVONNE: Uh-uh.
MP: No; you didn't draw any pictures about it or--?
YVONNE: Uh-um.
MP: Play it over and over--okay? Did you have bad dreams about what happened?
YVONNE: Yeah.
MP: And did you sometimes wake up and you couldn't remember the dreams but you knew you had a bad dream?
YVONNE: No; I was just blank--like I forgot everything that happened when I woke up.
MP: You forgot everything that happened, okay. Were there times when you were that age that you felt like the bad experience is happening all over again like it was yesterday?
YVONNE: Yes.
MP: Yeah; does that even happen now when--?
YVONNE: Yeah; when I hear shooting.
MP: Whenever you hear a shooting you--it feels like it's just happened all over again?
YVONNE: Yeah.
MP: How about do you begin--get really upset when you see or think about people, places, or things around what happened?
YVONNE: Yeah; like why--
MP: Like the house, the street?
YVONNE: Yeah.
MP: That all--even now or back then?
YVONNE: Just a long time ago.
MP: A long time ago; right after--after it happened did you ever feel like you know when you thought about it or people reminded you of it, did your hands get sweaty or anything like that or shaky?
YVONNE: My--yeah; my palms, they'd get sweaty.
MP: Your palms got sweaty okay. How long did that go on; do you remember?
YVONNE: No.
MP: A month or two months?
YVONNE: Yeah; around that timeframe--around that amount of time.
MP: How about when you thought about it or things related to it did your heart beat quick?
YVONNE: Yeah.
MP: Yeah; did you have trouble breathing at all like hyperventilating?
YVONNE: Uh-huh; I just--like I would start focusing on everything around me like making sure that the [inaudible] I was in was okay.
MP: Okay; did you ever get a bad feeling in your stomach?
YVONNE: Yeah.

MP: Yeah; whenever you thought about things related to it?
YVONNE: Yeah; and feel dizzy.
MP: You were dizzy too, okay. After that happened did you find you were trying to not think about what happened as best as you could--block it out?
YVONNE: Yeah.
MP: Did that go on for more than a month too--to block it out?
YVONNE: It helped a little bit like when I did other stuff, like sitting around it helped.
MP: Okay; did you try to block out--not have any feelings about what happened, not be sad, not be upset, not be scared--just sort of pushed away those feelings?
YVONNE: Yeah.
MP: And that went on for more than a month too and then after a couple months it stopped?
YVONNE: Yeah; kind of.
MP: Okay; did you try not to talk about what happened or did you talk about it?
YVONNE: I didn't talk about it.
MP: Didn't talk about it at all? For how long did you not talk about it?
YVONNE: I never really talked about it, like only when--like except like this and like when we--and different meetings, they'll ask like--they're like whatever bad happened like right in front of you, like that's the only time I will talk about it.
MP: Otherwise, you just put it in the past?
YVONNE: Yeah; I don't--.
MP: After it happened did you stop doing things that reminded you about it? Or you said--
YVONNE: I got on [inaudible] and my--.
MP: Even now?
YVONNE: Yeah; I [inaudible].
MP: Did--and you stay away from places that remind you about what happened?
YVONNE: Yes.
MP: And people that remind you about what happened?
YVONNE: They not around no more.
MP: Okay; when they were around did you avoid them?
YVONNE: Yeah; I--I would be with my mom and my brother.
MP: Stayed with your mom and your brother?
YVONNE: Yeah.
MP: Are there parts of what happened that you have trouble remembering, like you're kind of blank?
YVONNE: Yeah; like well I still don't remember where the dude came from.
MP: Oh really? You just remember the shot--
YVONNE: Yeah.
MP: --and seeing him and--and laying there? After that happened or even now were you less interesting in seeing friends or being with people?
YVONNE: That were there? No; I--

MP: Then or now?
YVONNE: Then I didn't want to be around nobody but like now I like being around people more.
MP: Okay; now it's better, okay--after that happened were you less interested in doing things you used to enjoy?
YVONNE: Yeah?
MP: Yeah; for more than a month like you just didn't want to do the stuff you used to like to do for a while?
YVONNE: It took me a good two years to start coming outside anymore. Like because I come outside now but not really because when all that happened like I used to never come outside no more.
MP: You never came out of your house after that? Did you--before that did you--
YVONNE: Like go to school--yeah.
MP: --come outside?
YVONNE: Uh-huh; I used to always be outside.
MP: You used to always be outside. That happened and you just decided not to come out anymore?
YVONNE: Yeah.
MP: Wow; that's pretty intense.
YVONNE: Because my mom, like she don't like us being outside because it's not safe no more, so like me and my brother we just go to school and we come straight home and we never come outside.
MP: Even now?
YVONNE: Like now I go to work and school and then after I get off work, like I say hi to everybody when I'm walking home or whatever, but I won't stay outside for more than 10--15 minutes.
MP: Uh-huh; so then you just--you didn't play outside anymore at all?
YVONNE: Yeah.
MP: For two years, okay; did you feel different to your classmates after that happened?
YVONNE: Uh-um.
MP: No; how about to your other kids?
YVONNE: Uh-um.
MP: You were fine playing with other kids and stuff?
YVONNE: Yeah.
MP: How about was it hard for you to feel things or show how you felt to other people after that happened?
YVONNE: To show how I feel.
MP: To show how you felt was hard to do after that happened?
YVONNE: Yeah.
MP: Okay; after that--since that happened did you change your mind about what you wanted to do in the future, for example did you change your mind about what you want to do when you get older?
YVONNE: Uh-um.

MP: How about--the idea of like getting married in the future--did that change?
YVONNE: Uh-um.
MP: How about becoming a parent in the future--did that change?
YVONNE: No.
MP: Okay; since that happened had you changed your mind about your chances of having a long life?
YVONNE: Yeah--now.
MP: How so?
YVONNE: Because it seems like now all teenagers don't live past the age of 18 and they're lucky if they live to be like 21. It's like everybody is dying young.
MP: Boys and girls?
YVONNE: Yeah, but mostly the boys.
MP: And did that--did that change a lot since you saw that person shot or just in general too?
YVONNE: Just in general like over the past three years like it feels like--like it seems like everybody is dying more, like I don't know. No, since like 2000 it seems like everybody is dying more.
MP: Have you known a lot of people who have died?
YVONNE: Yeah.
MP: Like how many--can you guess?
YVONNE: Like in my--just in my neighborhood over--I think over 12 people have done died in the last--
MP: In the last couple years?
YVONNE: --three years.
MP: Wow; are they all under 21?
YVONNE: Yeah; if they not dead they in jail and most of them is dead. Like three of them out of the whole 12 is in jail and other than that everybody else is dead and they was all under the age of 18 or they just turned 18. They just turned 18 right before they died or they turned 18 after they died. Like their birthday is in that same month or week.
MP: And how did that make you feel about it?
YVONNE: I--it's crazy; I feel like it's no controlling no more.
MP: You think that's all over the city or mostly your neighborhood or--?
YVONNE: All over the city.
MP: Yeah; like the kids are killing themselves--killing each other?
YVONNE: Yeah.
MP: Have people close to you been--?
YVONNE: Yeah; my god-brother was killed two months ago, I mean like two months or three months ago. He was killed in the back of his house and he [inaudible] too. He was killed in the back of his house and my cousin was there; it was a police chase that happened on [Alameny] and the police chased him in his truck and his truck was shot up over some--my auntie she investigated and everything else, but like it was like the main two people that I was real close to that died.

MP: Your god-brother and who else?
YVONNE: And my cousin.
MP: And your cousin--your god-brother just died--?
YVONNE: He had just turned 21--no, yeah--yeah, my god-brother died in the back of his house and my cousin, he died two years now.
MP: And do you--do you think about those--them a lot?
YVONNE: Yeah.
MP: And is that--
YVONNE: And [inaudible].
MP: And what do you think about when you think about them?
YVONNE: Like--because I might sit there and want to know why but most of the time when I think about it so I just sit down and write it to myself and that helps me express myself better than--and the writing like because usually--
MP: So writing helps you to--to deal with it?
YVONNE: Yeah; it helps me calm down like better--to just write to myself.
MP: Uh-huh; so that's--that's your way of kind of getting it out instead of talking to people?
YVONNE: Yeah.
MP: Uh-huh; that's really tough, yeah. We'll get through some of these and then we'll talk--talk a little bit more. After that happened, did you find it difficult to go to sleep or stay asleep at night?
YVONNE: Yes.
MP: And that lasted more than a month?
YVONNE: Yeah.
MP: Okay; did you find you got angry very easy?
YVONNE: Yes.
MP: And find yourself yelling at people?
YVONNE: Yes.
MP: Okay; getting in fights?
YVONNE: Yep.
MP: Having difficulty paying attention in class?
YVONNE: Yep.
MP: Became watchful or careful?
YVONNE: Yeah.
MP: Okay; after that happened did loud noises or sounds make you jump or jerk?
YVONNE: Yeah.
MP: They still do right?
YVONNE: Yep.
MP: Since that happened did you feel you were more upset than you used to be before it happened?
YVONNE: Yeah.
MP: How?
YVONNE: Because--
MP: Tell me ways that you--ways you felt more upset?

YVONNE: Because the littlest things like--I don't know; like I can wake up and have a--like somebody can just bang on the door and just because I'm already mad, I'm going to react like and then I'm going to act out like and it makes me even madder 'cause I'm already thinking about other stuff that may happen but the littlest thing it used to make me mad and just set me off.
MP: Okay; so if you're upset about somebody close dying or remembering this thing that happened--?
YVONNE: It's like I don't want to be bothered by nobody and I have people joke around and stuff like that.
MP: How do you mean joke around?
YVONNE: Like they were--like they just make little comments and maybe joke around like they just keep talking about it and I--I don't like when people keep talking about stuff that happened back to people that I was close to because it makes me keep thinking about it.
MP: So you'd rather that people didn't talk about it?
YVONNE: Yeah.
MP: You would rather keep it to yourself and write to yourself?
YVONNE: Yeah.
MP: Okay; after that happened or even the things that happened recently do you have problems with your classmates or other kids when you were that age?
YVONNE: No.
MP: Okay; so you get along with everybody?
YVONNE: Yeah as long as don't nobody make me mad it's okay. Like if they--I don't like when people play a lot like when we tell people to stop playing and they keep playing that irritates me. Like it's like it's a time to play and it's a time not to play.
MP: So when you get irritated--
YVONNE: Yeah; I'm mad at everybody.
MP: --you're mad at everybody okay, okay. And did that--was that different before that happened with that guy that was shot or the things--did you find yourself getting irritated more easily after people you care about are shot or lost?
YVONNE: Like when--yeah; if I really care about a person like that's how I be more irritated.
MP: Were you more irritated about that guy that was shot in front of your house?
YVONNE: Uh-um; it just scared me like--
MP: Just freaked you out?
YVONNE: --because I never seen nothing like that before.
MP: Yeah; how about your grades in school--did they go down after that happened?
YVONNE: Yeah.
MP: And do they go down now when something bad happens?
YVONNE: Yeah, sometimes.
MP: Because you have a little trouble concentrating?
YVONNE: Yeah; concentrating.

MP: Did you have more troubles with your mom or your brother after that shooting happened or after--?
YVONNE: No; they was both there to comfort me.
MP: That's good; how about after your cousin and your god-brother?
YVONNE: Everybody was there to comfort each other.
MP: So they helped you through it?
YVONNE: Yeah.
MP: Okay; did you have any more troubles with teachers after these things have happened?
YVONNE: No.
MP: No, okay; all right, so the problems you had after the guy was shot when you were eight did you have most of those problems for less than three months?
YVONNE: Yeah.
MP: Okay; were there any problems that started to begin after like six months, sort of kicked in later?
YVONNE: Just more people like--more people started dying like and I understand everything better because after I seen that like I just started paying attention to everything more.
MP: Okay; hmm so you're more aware of things?
YVONNE: Uh-hm.
MP: Okay; and now there have been some problems that you've had for the past three--over three months?
YVONNE: Well yeah.
MP: Uh-huh, like what?
YVONNE: Like because I'm--like relationship problems and like family problems and school and work. Like the [anxiousness]--that's been a lot of stress on a lot of teenagers but it's not right--if I get all my credits and I'm trying and everything else, like and it all depends on if I graduate or not because of a test.
MP: Uh-huh; so--so stressful things make you really upset?
YVONNE: Yeah, yeah.
MP: You get anxious easy?
YVONNE: Yeah.
MP: You have trouble sleeping sometimes when you feel that way or--?
YVONNE: Like--uh-uh--[inaudible]. I'll just go be by myself and then go lay down for a little bit.
MP: Oh it makes you feel better, okay?
YVONNE: Yeah.
MP: Okay; and you said--okay, I think I got it. How much time do we have? What time do you have to go?
YVONNE: [Inaudible] at 1:00.
MP: What time is it now?
YVONNE: Twelve thirty-eight.
MP: Oh, okay; so--so some of the--some of the more extreme things like the trouble sleeping and stuff like that went away you said after a couple months?

YVONNE: Uh-hm.
MP: And other things like watching out where you go and everything like that--stuck around?
YVONNE: Yeah.
MP: Kind of--and staying in and things like that?
YVONNE: I just keep to myself. I think it's better if I just keep to myself.
MP: Okay; so ever since then you've been keeping to yourself.
YVONNE: More yeah.
MP: Some of those--the things have like--thinking about it all the time, having trouble--getting bad nightmares, sweaty palms, and everything like that, did that go away after a while?
YVONNE: Yeah.
MP: Okay; I'm done with that. Done with that; now I'm going to ask you more kind of general questions and then we can talk about these. So you described some difficult experiences you had and I'm just wondering how do you think you got through them.
YVONNE: By writing to myself.
MP: Uh-huh, by writing?
YVONNE: Instead of acting out.
MP: Instead of acting out?
YVONNE: Yeah.
MP: Writing like a journal and things like that?
YVONNE: Yeah; in a notebook.
MP: A notebook; how would you act out?
YVONNE: Like--I don't know; like the little stuff irritates me so like if somebody do something--somebody bumps into me I'll make it bigger than what it needs to be.
MP: What's that?
YVONNE: I'll make it bigger than what it needs to be like--I don't know; sometimes I'll fight and sometimes I don't. Like I'll argue with people or I might cuss you out. But it all depends like on how my day is.
MP: But that's gotten a little bit--?
YVONNE: Yeah; it's gotten better, like I just write to myself now more and then it helps.
MP: Uh-huh; so some ways that you've learned to cope with these difficult things that have happened to you is writing?
YVONNE: Yeah.
MP: Okay; any other ways?
YVONNE: Uh-um.
MP: Can you describe--all right, [Rudy], [Rudy], keep it down just a little bit so the recording--thanks man.
YVONNE: Hmm; that's funny.
MP: He can talk.
YVONNE: [*Laughs*]

MP: Can you describe parts of what happened that still bother you--of anything--?
YVONNE: I don't think about it--uh-uh.
MP: Nothing?
YVONNE: Uh-um, like if I see the person again like the people that was there at the event it will make me think about it again.
MP: When the guy was shot?
YVONNE: Yeah; like if I see the people here--the people that was there it makes me think about it again.
MP: Okay; are there certain memories or experiences that are harder to forget or get rid of?
YVONNE: Uh-um.
MP: No? They're all going--fading away?
YVONNE: Yeah.
MP: What about other things like the violence that you've seen of people being shot in your neighborhood or anything like guns going off?
YVONNE: I'm used to that now like it don't even bother me anymore.
MP: It doesn't bother you anymore? What about things or people that you care about--are killed, like your cousin and your god-brother, does that come back in your mind a lot?
YVONNE: Yeah.
MP: Is that hard to get--get rid of or do you get used to that too?
YVONNE: I'm kind of used to that now 'cause it happened like a little while ago like--so I'm used to that.
MP: But you said your god-brother just died--
YVONNE: Yeah; like a few months ago--like two months ago, but like it happened--I already know like it's a time for everybody to go so like I was--I trip on it still but not like--I think about it to myself and write something down about it, but I really don't say nothing to nobody else about it.
MP: Okay; and you're getting--and you feel like you're getting past it?
YVONNE: Yeah; a little bit.
MP: How do you feel that you get past things like that--write them down and--?
YVONNE: Just write them--I think writing has just helped me a lot like for all my situations--good or bad.
MP: How does it help you?
YVONNE: 'Cause instead of acting out in a violent way and fighting like I'd rather just write it down.
MP: What do you write, like what you want to do to someone or--?
YVONNE: Like what happened, like what made me mad, and like--I can be like oh here's what happened or like this one made me mad, like this one ticked off--the littlest stuff.
MP: So you write it rather than react to it?
YVONNE: Yeah.
MP: I got you, and does that help you deal with missing people who are gone?

YVONNE: Yeah.
MP: Okay; so rather than talking to people and digging it all up you write it down?
YVONNE: Yeah.
MP: That's what you prefer okay. After these things have happened do you--you know how have these experiences changed your life whether it's watching the shooting when you were eight or knowing so many people in your neighborhood and close to you getting shot?
YVONNE: It's just knowing all the people--what you mean--the change?
MP: How has it changed your life, like how do you think you'd think or feel before these and how you feel differently now? How has it changed your view of life for yourself?
YVONNE: Like it's not that much time, so instead of tripping on all the little stuff and arguing with people like do what I need to do to better myself and to get away from all this like--and so I can be a better person on my own.
MP: So you don't trip off on the little things anymore?
YVONNE: No, not really.
MP: You focus more on--?
YVONNE: The important things, yeah.
MP: The important things; so in that way do you think it's helped you--what?
YVONNE: It helps me to better myself in the end--
MP: More mature or--?
YVONNE: Yeah; helps me better myself as a young person.
MP: Uh-huh; so it hasn't all been bad? It's actually helped you--?
YVONNE: Yeah; like I'm happy I seen some of the stuff that I've seen and some of the stuff that happened 'cause it made me think like it's not just a small world and things do happen like and it made me--I don't know; like it just made me better myself as a person like I see stuff that goes on around me and I don't want to be involved with that, so I try my best to stay away from like all the messy stuff, the drama and everything else and the gangs and everything else and just like--just do what I need to do to get out of here.
MP: Where is out of here?
YVONNE: Like the city, like San Francisco--period.
MP: Uh-huh.
YVONNE: And that's like when we'll be in [UP], like [Rudy]--they take us different places or whatever and they help us see stuff that we ain't never seen before. Like [Rudy] showed us these old pictures of all like this stuff that he went through and like I just hope it like helps me more like he's changed as a person, so that means it is a chance for everybody to change; they just really got to want it.
MP: So seeing people like [Rudy] and people in [UP] change their lives inspired you?
YVONNE: Yes.
MP: Is that what you're saying--okay; is that how [UP] has helped you the most?

YVONNE: Yes.
MP: Okay; to show you that there is a way out?
YVONNE: Yeah.
MP: Is that what you mean?
YVONNE: Yeah.
MP: Okay; if you could change anything that has happened in your life what would you change?
YVONNE: When we moved over here--when my mom moved to San Francisco--well not [inaudible] but when she moved to Sunnyvale, like I--I preferred for us to stay somewhere else, but not even--I wouldn't even prefer for us to stay someone else because this problem is everywhere that you go. I'm going to change [inaudible].
MP: Okay; are you hopeful for your future?
YVONNE: Yeah.
MP: Good for you. So some other questions I have--open--. What do you think--what do you--what do you think about all the violence among kids?
VONNE: I think it's--'cause teenagers got so many problems now and I think--they just--that's just their way of expressing their self, even though it's not smart or right but that's just their way of expressing things or whatever.
MP: Expressing what?
YVONNE: Like all their feelings, like all the stuff, 'cause sometimes teenagers--
MP: What is the stuff that they're so upset about--?
YVONNE: They probably got problems at home, like it's people outside that don't like them, like or whatever they're--I don't know--school problems like the tests and stuff, their grades will bring them down, the teachers they probably don't get along with them really, like people at your school, they don't like you to where you don't feel comfortable going places. It can be a lot of stuff.
MP: Uh-huh; so are you saying that kids get violent because they're brought down?
YVONNE: Yeah.
MP: So they feel bad about themselves and--?
YVONNE: So they bring other people down with them.
MP: Got you; what do you think the solution is to violence among kids?
YVONNE: I don't think there is a solution.
MP: What do you think would be some ideas of ways it could be made better?
YVONNE: I think probably if there was more programs like [UP], like it will help--.
MP: More programs?
YVONNE: Yes; like a different--like yeah, like for just teenagers.
MP: Programs that do what for them?
YVONNE: Are like that take them outside and like show them other parts of the city, other parts of the world, and show them different stuff, like [Rudy] and them take people to the jails and stuff and so they can see how the people in there live. I think that helps too a lot.

MP: Uh-huh; so you think programs like [UP] help?
YVONNE: Yeah.
MP: Help kids deal with violence in different ways?
YVONNE: Yeah.
MP: Are there other things--other people or other things that have--that you see helping kids with violence?
YVONNE: It's like if you don't want to--
MP: Or you--that's helped you--either one?
YVONNE: Uh-um.
MP: You told me writing helps.
YVONNE: Yeah; writing.
MP: How about--how about people and places and things?
YVONNE: Well my supervisors, like by me going to work it keeps me--how to--like when I go to work instead of being at work, I could be outside hanging out and everything else, but there I do something productive and I go to work to keep myself away from everything else. And at the same time I'm learning different things every day from other people.
MP: That helps you feel like you're accomplishing something?
YVONNE: Yeah.
MP: And you think that would help kids too--be less violent and getting in trouble?
YVONNE: Yeah.
MP: What about things like guns and all that--do you think if--do you think that's part of the reason there's so much violence or do you think it's the violence making it--access to guns?
YVONNE: Yeah; the violence makes access because it's easy for anybody to get a gun now.
MP: Uh-huh; so you think the problem is more that--
YVONNE: There's too many weapons, like not even a gun--people fight too and stab each other and everything else.
MP: Yeah; so you think the real reason for the violence is what--just feeling bad about themselves?
YVONNE: Basically like they're depressed and they stressed out on their own self so they taking it out on everybody else that's around them.
MP: Okay; I'm trying to think. Are there--are there other questions you have for me? Anything else you want to say about how kids deal with violence, how violence affects kids, solutions--?
YVONNE: Uh-uh; we--I was at a meeting yesterday and we was talking about this, so--
MP: Yeah; what did some of the other kids come up with?
YVONNE: They--the same thing like we just need a different--like everybody needs a program that they can go to 'cause this program--everybody can be like they'll be doing something to better their self and they'll be learning at the same time.

MP: What--what--what kind of program--do you think one type of program is best for everybody or what--are there different programs for different kids?
YVONNE: Like when kids--they will just sit down and talk because in group they want to sit down and talk like about everyday stuff and they'll go on [inaudible]--and I think that helps a lot like--
MP: [Rude] to the program or you mean [rude] to the movie?
YVONNE: No; the program.
MP: Okay. [*Laughs*]
YVONNE: It's next door or across the hall like and it's a classroom or whatever and they sit down and talk about stuff that happened every day or whatever and like what affects them or whatever and I think that helps when people just sit down and talk about it.
MP: Getting it off their chest?
YVONNE: Yeah.
MP: So they don't hold it inside?
YVONNE: Yeah.
MP: And then they can talk about it and can write about it in different ways?
YVONNE: Yeah.
MP: So you think programs that let kids talk about what they're dealing with--?
YVONNE: Yeah and some people think this is just it, like they never--they think that's just it. Like I mean it's better when they get--like it's just better for them like 'cause they're learning new stuff and they're going to get [took out of the] city. I know people that have never been out of San Francisco.
MP: It sounds like--you've said that a couple times--it sounds like that has shown you that there's a different way of living.
YVONNE: Yeah; 'cause I've been to a whole bunch of different places. I've been in New Orleans before it got flooded, I been to Washington before, and like I see how everything is out there, like--and like how it is, like I guess the same out here but they're not real like--it's people that try like and then when I watch stuff on TV, they talk about the kids that don't got no school and everything else, like they really wanted to make me appreciate school more 'cause like I'm lucky to have it and these people don't have it but they really, really want it. There's people out here that like they want it but then they don't really--like they're using it and taking it advantage 'cause they already got it and they don't got to pay for it; so--.
MP: So seeing what other kids have to deal with--?
YVONNE: Go through yeah.
MP: It helps you have a different perspective; is that what you mean?
YVONNE: Yeah.
MP: Okay; that's--that helps, okay. Any questions for me?
YVONNE: Nope.
MP: This was very good. Thank you very much
YVONNE: Uh-hm.