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The Impact of Post Traumatic Stress Disorder on Recurrent Violent Behavior among African American Males

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Abstract

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MAEd, East Carolina University, 2000

BA, Denison University, 1996

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

African American men in their late teens to early 20s account for nearly half the victims of violent crimes. This mixed methods social epidemiological study was designed to identify the social determinants of violence as described by a purposive sample of young adult African American men (*n*=353) who have experience as a victim or witness to any type of violence to determine the impact post traumatic stress disorder (PTSD) symptoms have on recurrent violent injury. The pathways to recurrence model shaped the theoretical framework of this study. Quantitative data were collected using the Past Feelings and Acts of Violence (PFAV) instrument and the PTSD checklist civilian version (PCL-C). Logistic regression and Pearson correlation analysis techniques were used to examine correlations between the variables. The results showed that with higher levels of past violent behaviors there is an increase in PTSD symptoms. Qualitative data regarding exposure to and experiences with violence were collected from a subgroup of participants using open-ended, semistructured interviews (n=5) that were later analyzed using a phenomenological approach. Weapon-carrying, living in urban settings, and gang presence were themes identified by those interviewed as being related to recurrent injury. These findings will encourage social change by stimulating new strategies aimed at long-range systems changes by those who shape policies and influence community investment and engagement in resource –poor communities where violence is prevalent. More research is needed to determine if early identification and treatment for PTSD among African American men who have been exposed to violence may reduce the incidence of future violence and injury.

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Chapter 1: Introduction to the Study

Violence has become a significant public health problem (Baxendale, Cross, & Johnston, 2012; Chen, 2010); it has an effect on Americans from all demographics (Baxendale et al., 2012; Chen, 2010; Ellickson, 2000). Violence disproportionately affects African American youth, particularly African American males (Chen, 2010; Corbin et al., 2011; Hall, Cassidy, & Stevenson, 2008; Pizarro, 2011; Copeland-Linder et al., 2010). There are numerous factors that may have an impact on violent behavior (Cross, 2003; Ellickson, 2000; Livingston, 2006; Noguera, 2002; Oliver, 1994; Richards, 2004; Singh, 1996; Washington, 1997; Williams, 2004).

This mixed methods social epidemiological study includes a description of the phenomenological experiences of African American men with violence. This approach underscores the importance of understanding the perceptions and lived experiences of African American men and how those experiences influence their responses to community violence exposure. I examined the relationship PTSD and exposure to violence has on recurrent injury among African American men.

In this chapter, the problem being studied will be introduced. The research questions and the hypotheses being tested will be presented and the purpose and nature of the study will be discussed. The conceptual framework and its use in this study will be described. Finally, the significance of the study and the implications for social change will be presented.

Background

Young African American males experience high rates of violence (Chen, 2010, Mitchell, 2010, Pizarro, 2011). African American accounted for 13% of the population in 2005; however, that same population made up 49% of all murder victims, 50.9% of homicide arrest in 2006 (Kaufman, Rebellon, Thaxton, & Agnew, 2008), and 15% of rapes, assaults, and other nonfatal violent crimes (Harrell, 2007; Jordan, 2007). Of African American victims, 85% were male with 51% of them between the ages of 17 and 29, as compared to 37% for White males of the same age group (Harrell, 2007; Jordan 2007). Homicide trends from 1980-2008 showed 93% of African American murder victims were killed by other African Americans (U.S. Bureau of Justice Statistics, 2011). Pizarro (2011) found that among homicides committed between 1997-2007, 88% of offenders and 83% of victims were African Americans.

Historically, African Americans, especially African American males, have been the victims of violence (Jackson, n.d.). Adolescent African Americans are disproportionately affected by poverty, crime, limited police protection, and disrupted familial relationships (Copeland-Linder et al., 2007; Hall, Cassidy, & Stevenson, 2008). As a result, African Americans, particularly men, are also likely to experience exposure to and experiences with interpersonal violence (Chen, 2010; Hall et al., 2008). Chronic exposure to these risks may increase the odds of being victimized or becoming a victimizer.

According to Bell (2004), the oppressed often adopt the point of view of the oppressor. Experiencing violence may increase the likelihood that a person will use

violence against others (Allwood & Bell, 2008; Begic & Jokic-Begic, 2002; Bell, 2004; Collins & Bailey, 1990; Copeland-Linder et al., 2012; Corbin et al., 2011). Victims of violence often become perpetrators themselves (Allwood & Bell, 2008; Begic & Jokic-Begic, 2002; Shields et al., 2010). Some perpetrators of homicide have demonstrated symptoms of PTSD (Pollock, 2000), such as depression and anxiety (Chen, 2010) which could be a factors that contribute to violent behavior.

The risk of being a victim of violent crime is high for African American male adolescents (Bell, 2004; Cassidy, 2005; Fingerhut, 1992; Pizarro et al., 2011; Reed et al., 2010; Robinson et al., 2011; Spano, 201;). When compared to White males, African American males are three times more likely to live in poor, high crime urban environments (Boyle & Hassett-Walker, 2008; Cassidy, 2005). African American male youth are twice as likely to be injured or killed during their adolescence than their Caucasian counterparts (Cassidy, 2005). African American males who are under the age of 25 are 15 times more likely to die due to homicide than White males under in the same demographic (Cottman, 2008).

While homicide rates have trended downward through the years, rates for non-Hispanic African-Americans have remained consistently higher than all other racial/ethnic groups (Centers for Disease Control and Prevention [CDC], 2013). The majority of these homicides were caused by firearms with a rate of 48.4 per 100,000 for African American males age 10-24 (CDC, 2013). In regards to intentional violence, many African American males were killed by other young African American males (Cassidy, 2005; Felson & Painter-Davis, 2012; Kochanek, 1994; Singh, 1996; Wallace, 1995).

Some African American males may be socialized to exhibit exaggerated masculinity (Watkins et al., 2010); therefore, some often choose to show aggression to cope with social pressures (Cassidy, 2005). Vulnerabilities felt by African American males is disguised by the masculine masks they wear (Cassidy, 2005).

Post Traumatic Stress Disorder (PTSD) is an anxiety disorder that may influence violent behavior among African American males. PTSD may develop due to a variety of traumatic events (Hall, Cassidy & Stevenson, 2008; Iverson et al., 2011; McGruder-Johnson et al., 2000; Richmond, et al., 2011). Interpersonal violence or witnessing traumatic events are likely to cause PTSD symptoms (Breslau, 1999; Copeland-Linder et al., 2010; Corbin et al., 2011; Freedy et al., 2010; Hall et al., 2008; Kelly et al., 2010; McGruder-Johnson et al., 2000; Mitchell et al., 2010; Mokrue et al., 2011; Streets, 2011; Sturm, 2012). Ethnic minority groups may have higher rates of PTSD (Mitchell et al., 2010; McGruder-Johnson et al., 2000; Roberts, et al., 2011; Sturm, 2012). Breslau et al. found that women and people of color were more likely to experience PTSD than men and Caucasian Americans respectively. It is not clear why ethnic minority groups experience more maladjustment and posttraumatic symptoms; but, it is speculated that increased exposure to violence may account for this disparity (Chen, 2010; Corbin et al., 2011; Hall et al., 2008; Kelly et al., 2010; McGruder-Johnson et al., 2000; Mitchell et al., 2010; Sturm, 2012). Prevalence rates for PTSD are 7% to 11% for people exposed to violent crimes, deaths, or accidents (Breslau, 2001). The rates of PTSD may be as high as 22% following a traumatic event (Richmond et al., 2011). African Americans and Hispanics report being exposed to more violence than Caucasian Americans (Breslau,

2001; Corbin et al., 2011; Chen, 2010; Mitchell et al., 2010; Sturm, 2012). The combination of trauma exposure and stressful social conditions increase the likelihood of PTSD symptoms in minority groups (Chen, 2010; McGruder-Johnson et al., 2000).

It is hypothesized that African Americans experience higher rates of PTSD because they are confronted with more serious traumatic events and have fewer economic resources that would enable them to recover sooner, in comparison to their Caucasian American counterparts. African Americans are also exposed to greater hostility, prejudice, and neglect (Hall et al., 2008; Kelly, et al., 2010; McGruder-Johnson et al., 2000; Mitchell et al., 2010). Other risk factors for PTSD include lower education level (i.e. less than a college education), a pattern of childhood behavioral problems, extraversion, depression, anxiety, and family history of psychological disorders or substance abuse (Breslau, 2001; Mitchell et al., 2010).

Few studies comparing racial/ethnic groups have controlled for the effects of lifetime exposure to trauma or secondary exposure, like witnessing violence (McGruder-Johnson et al., 2000). Roberts et al. (2011) found that the lifetime prevalence of PTSD and the risk of experiencing PTSD following a trauma was highest among African Americans. African Americans and Hispanic Americans had higher risk of child mistreatment and witnessing domestic violence than Caucasian Americans (Roberts et al., 2011). It is not clear if the relationship between violence exposure and psychological distress influences recurrent injury among African American men.

Statement of the Problem

Violence is a significant public health concern that disproportionately affects African American youth, particularly African American men (Hall et al., 2008). Some of the factors that have an impact on violent behavior include poverty, crime, disrupted family life, limited protection from police, and exposure and experiences with interpersonal violence (Hall et al., 2008).

Some individuals who have continuous experiences with and exposure to violence may develop PTSD-like symptoms such as anxiety, depression, feelings of helplessness, and emotional numbing (Donley et al., 2012; Hall et al., 2008;). It is not clear if recurrent violent behavior among African American males is associated with these symptoms. However, due to higher rates of exposure to violence among African American men, as either a victim or a witness, they develop PTSD symptoms at a higher rate than other groups. This leading to an increased propensity towards future violent behavior.

The question this study intends to answer is if past exposure to violence, either as a witness or as a victim, causes African American males to be at a greater risk of developing PTSD symptomology and whether the development of PTSD symptomology leads to a greater propensity to commit future acts of violence. I will lay the groundwork for future research regarding the relationship between PTSD and subsequent violence.

Purpose of the Study

I investigated the impact of PTSD on young adult African American men who have experienced with violence. In addition to determining the prevalence of violence against African American males, I sought to determine if there is any association between

recurrent perpetration of violence and PTSD. I also sought to establish if there was a relationship between having witnessed or experienced violence and the development of PTSD among African American males. The independent variables are exposure to violence and PTSD symptoms and the dependent variable is violent behavior. The expected outcome of this study was to provide evidence to support interventions that address violence and PTSD among African American males, particularly following an injury.

Research Questions

Qualitative Research Question 1: What are the thoughts, actions and behaviors of young African American men who are exposed to violence?

Qualitative Research Question 2:What are the influencing factors associated with recurrent violence among young African American males?

Quantitative Research Question 3:What is the relationship between PTSD-like symptoms and interpersonal violence among African American men who have been either a victim or witness of violence?

H_0: African American men who have experienced interpersonal violence will not report fewer PTSD symptoms as evidence by scores on the Post Traumatic Checklist-Civilian (PCL-C).

H_A: African American men who have experienced interpersonal violence will report fewer PTSD symptoms as evidenced by scores on the Post Traumatic Checklist-Civilian (PCL-C).

Quantitative Research Question 4: To what extent is there an association between PTSD symptoms and violent behavior among African American men?

H_0: African American men who exhibit any PTSD symptoms will not report past acts of violent behavior as evidenced by scores on the Past Feelings and Acts of Violence (PFAV) Questionnaire.

H_A: African American men who exhibit any PTSD symptoms will report past acts of violent behavior as evidenced by scores on the Past Feelings and Acts of Violence (PFAV) Questionnaire.

Conceptual Framework

The conceptual framework for this study is that young African American males are disproportionately exposed to violence as victims or witnesses (Chen, 2010; Copeland-Linder et al., 2007; Felson & Painter-Davis, 2012). Due to their exposure to past violence, young adult African American men are at an elevated risk of experiencing PTSD (Chen, 2010; Corbin et al., 2013; Donley et al., 2012). Higher PTSD symptomology can lead to future violent behavior or at least an increased propensity for the use of violence (Donley et al., 2012). This concept is based on the pathways to recurrence model developed by Rich and Grey (2005). This theory posits that exposure to violence and traumatic stress due to injury creates a cycle of recurrent injury (Rich & Grey, 2005). The conceptual model is empirically investigable both qualitatively and quantitatively; it contains all of the elements found within the four research questions this study intends to answer, as well as whether or not exposure to violence and the experience of PTSD influence future violence among young adult African American

men. More on the conceptual model and the pathways to recurrence model will be discussed in Chapter 2.

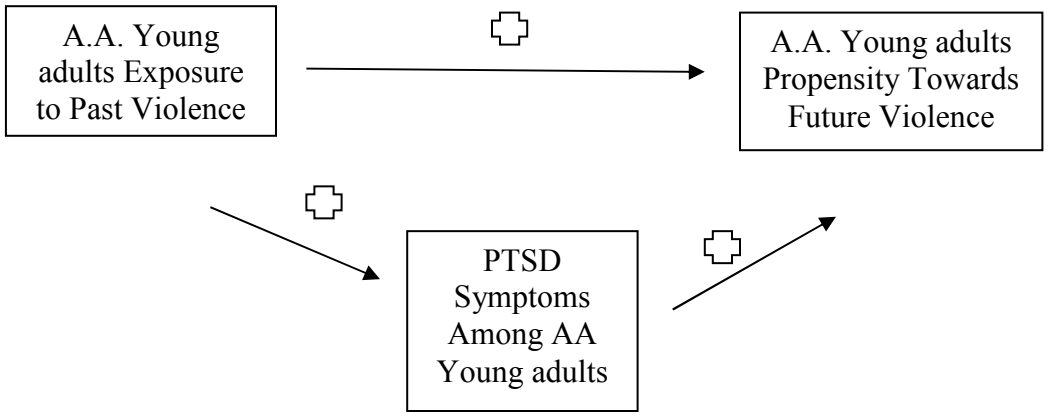

Figure 1. Rich and Grey model.

Nature of the Study

I selected a mixed methods approach because both quantitative and qualitative data were collected. The independent variables were exposure to violence and PTSD and the dependent variable was violent behavior. Violent behavior was measured using the Past Feelings and Acts of violence (PFAV) scale developed by Plutchik and van Pragg (1990). Items adapted from the PTSD checklist civilian version (PCL-C) were used to assess PTSD symptoms (Weathers, 1994). The sample was composed of African American men between the ages of 18 and 24. Participants were recruited from a city in Eastern North Carolina, which, according to crime statistics had high incidents of assaults. Study participants completed the PFAV and PTSD Checklist. Qualitative data regarding the experiences participants have with violence were collected through in-depth interviews. Quantitative data were analyzed using logistic regression and Pearson

correlation to determine any association between the variables. Analysis was done using SPSS software. Qualitative data was analyzed using a phenomenological approach. The methodology will be described further in Chapter 3.

Definitions

Assaultive violence: Assaultive violence is physical force that is used to cause harm or death to another person (Sanders-Phillips, 1997).

Community violence: Community violence is violence that happens in the community (Sanders-Phillips, 1997).

Delinquent: Someone, who is usually a young person, who engages in behavior outside of what is generally viewed as acceptable (Rozie-Battle, 2002).

Hypermasculinity: An exaggerated sense of what it means to be male (Cassidy & Stevenson, 2005).

Hypervigilance: An exaggerated awareness of danger (Cassidy & Stevenson, 2005).

Hypervulnerability: A sense of exaggerated vulnerability; feeling that one is in a constant threat of being attacked (Cassidy & Stevenson, 2005).

Interpersonal violence: Violence that occurs between, friends, family or acquaintances (Scarpa, 2003).

Subculture: A value system that transcends geographic places in society (Cao, 1997).

Operational Definitions

Violence: The World Health Organization (WHO, 2002) defined violence as the intentional use of force that results in injury, death, or harm. For the purposes of this study, violence refers to engaging in physical fights (i.e. assaults), being stabbed, being shot at, or being shot.

Posttraumatic stress disorder: Emotional or psychological distress experienced following a traumatic event (Sanders-Phillips, 1997). For the purposes of this study, PTSD symptoms will be defined by responses to the PTSD Checklist that correspond to key symptoms of PTSD according to the DSM-IV.

Assumptions, Limitations, Delimitations

Assumptions

The primary assumption is that being exposed to violence can cause PTSD-like symptoms, resulting in feelings of hypervulnerability and hypervigilance. The combination of an elevated sense of vulnerability and hypermasculinity may produce an environment conducive to violence. The danger of violence or witnessing violence in poor neighborhoods and the need to affirm their masculinity, and experiencing PTSD symptoms due to violence may stimulate violent reactions in African American males if confronted with a perceived threat.

Limitations

On the quantitative side of the study, the sampling technique may limit the generalizability of the results. The participants may not be representative of the entire population. Another limitation is that the PTSD checklist is a self-assessment tool and

cannot be used to diagnose PTSD. It is a standardized rating scale that corresponds to the key symptoms of PTSD and is used by both military and civilian professionals. A third limitation is self-reporting. The data depend on self-reports from the participants and participants may have tried to answer questions in a way that would please the researcher. To encourage truthful responses, the interview questions and surveys were confidential. There may also have been some recall bias if the participant's most recent experience with interpersonal violence has been longer than one year. An attempt was made to recruit participants who have experienced the phenomenon being studied within the past year, to increase the likelihood that their experiences were fresh in their memories. Some individuals may also have been apprehensive of reporting their experiences, especially if their actions involved illegal activities. Participants were instructed that their responses were confidential and I am the only person with access to their responses.

Delimitations

The sample composed of African American men who are between the ages of 18 and 24. This population was chosen because African American men are affected by the consequences of violence in profound ways, including high incarceration rates and high homicide rates.

Significance of the Study

This study has several implications. The principal purpose of this study was to better understand how exposure to violence influences violent behavior among African American men. A lot of attention has been focused on the problems caused by traumatic stressors, but not on subsequent violent acts due to these stressors (Collins & Bailey,

1990; Rich & Grey, 2005). This study may provide insight on the role, if any, that PTSD plays in subsequent violence. Examining the connection between these variables may lead to the development of behavioral or medical interventions that considerably decrease violence and reduce the consequences of violent behavior among African American men. If suitable interventions can be developed to address traumatic stress among young African American men and show them how to constructively manage the stress they experience in their lives and neighborhoods, perhaps these young men can be diverted away from confrontations that could lead to injury, incarceration, or death.

There are several possible implications for social change that may come out of this study. This study will provide a better understanding of how PTSD symptoms influence the risk for young adult African American men to become involved in violence. A better understanding of trauma and trauma reactions may be helpful in the development of focused therapeutic and prevention efforts for this at-risk population. Long-range systems changes that include the development of policies, programs, and interventions targeted at addressing those social and environmental risks common in resource-poor neighborhoods where rates of violence are highest may assist in reducing exposure to violence, thereby reducing homicide and incarceration rates among young African American men.

Homicide has had an impact on the life spans of African American men and has contributed to the fragmentation of African American families. If violent confrontations can be decreased, perhaps homicide rates can be reduced. Decreases in homicide rates may also lead to reductions in violence-related incarceration rates.

High rates of unemployment have a great impact on the stability of African American families. Unemployed African American males may turn away from their families when they are not able to provide for them. This creates a context of fatherlessness, economic instability, poverty, and hopelessness; in turn, this is manifested in children by low expectations, high rates of high school drop-outs, and increased rates of delinquency (Livingston, 2006). A reduction in violent crimes may help to reduce incarceration rates thereby increasing social and familial stability in African American communities.

Costs related to trauma-related stress disorders can be high. In 1991, estimated costs to treat the 4.7 million crime victims who received mental health treatment was $9.7 billion, representing only a small portion of those needing treatment (Cohen & Miller, 1994). Marciniak (2005) examined the cost of treating anxiety estimated the average total medical care costs for those diagnosed with any anxiety disorder to be $6,475 per patient. For PTSD, the cost was estimated to be $3,940 per patient (Marciniak, 2005). Those with the highest costs and greatest need were patients diagnosed with depression, PTSD, and those with comorbid conditions in addition to anxiety (Marciniak, 2005). Prompt diagnosis and adequate treatment of trauma-related disorders, like PTSD, are the most economical and effective means when compared to the cost of wrong or insufficient treatment (Loewenstein, 1994). Ross and Dua (1993) found that correct diagnosis of trauma related disorders could save an estimated $250,000 per patient in total treatment costs. Other outcome data suggests that short-term specialized treatment programs for PTSD are more beneficial and cost effective than long-term specialized care or non-

specialized care (Fontana & Rosenheck, 1997). It is efficacious to provide early, correct diagnosis and treatment for trauma induced stress disorders. Adequate treatment of PTSD symptoms may reduce health care costs due to recurrent injury from violence. By reducing violent behavior and diagnosing and treating PTSD early, billions of dollars could potentially be saved in the health care system.

Summary

African Americans are disproportionately affected by barriers to positive health outcomes. Crime, poverty, and fragmented familial relationships are a few risks that are increasingly more common in predominately African American neighborhoods. African Americans are also especially likely to experience interpersonal violence (Hall et al., 2008). Ongoing experiences with violence may cause symptoms of PTSD to develop which may influence violent behavior.

The following chapters will provide a more detailed discussion of the current literature on violence and African American men as well as PTSD and violence. Chapter 2 is a review the literature on African American men and violence. There will also be a more detailed discussion of PTSD and violence. Chapter 3 is a description of the methodology of the study. The research design will be described in detail, including the instruments used, sampling technique, data collection strategy, and proposed data analysis. Chapter 4 is a report of the data and Chapter 5 includes analysis and recommendations for future study.

Chapter 2: Literature Review

Introduction

The purpose of this literature review is to provide an overview of the problem of interpersonal violence among young African American men. This review of the literature will identify psychological responses to community violence, particularly posttraumatic stress, as well as discuss some of the theories offered to explain interpersonal violence among African American males.

A computer-aided literature search was performed to find research studies and articles about the incidence of injuries due to violence and the psychological effects of violent injuries for young adult African American males. The databases that will be searched will include Academic Search Premier, GoogleScolar, CINAHL, ERIC, PsycInfo, SocINDEX, OVID Nursing Journals, Criminal Justice Periodicals, Proquest Nursing and Allied Health Sources using *violence, homicide, African American males, exposure to violence*, *and post traumatic stress disorder* as key words. Literature will be searched for years 1990-2000 when violent crimes were at its peak as well as current research from 2005-2013.

Violence Among African American Males

Perpetration

People of color are disproportionately affected by violence, as both victims and perpetrators (Franke, et al., 2002, Reed et al., 2010). Greater incidence of violent acts has been associated with being African American, male (Baxendale et al., 2012), adolescent, and of lower socioeconomic status (Baxendale et al., 2012; Franke et al., 2002 ;). African

American males are at an increased risk of involvement in violence as offenders and victims (Pizarro et al., 2011), especially if they come from a family with lower socioeconomic status (Baxendale et al., 2012; Franke et al., 2002).

An increased risk of violence perpetration exists in adulthood when exposed to violence as a victim or witness (Duke et al., 2010). The literature further supports the relationship between family violence and sexual assault victimization and male intimate partner violence perpetration (Loh & Gidycz, 2006) and neighborhood violence exposure and intimate partner perpetration by men (Luthra & Gidycz, 2006). Felson and Painter-Davis (2012) showed that offenders were mostly African American, male, and young adults. Young adult African American male offenders who live in disadvantaged, urban communities were more likely to use guns against another young adult African American male (Felson & Painter-Davis, 2012). Felson and Painter-Davis found that 30% of assaults that involved the use of a gun was against another African American male.

Being raised by a single, female parent may also be a contributing factor to future violent behavior. Increases in juvenile homicide rates between 1970 and the 1990s were influenced by declining economic prospects and the prevalence of female-headed families (Ousey, 2000). Some scholars have suggested that a proliferation of female-headed households reduces a community's ability to supervise the activities of young people and to teach acceptable mainstream values, resulting in more illicit behavior, including violence (Ousey, 2000). Strong family bonds have been associated with more supervision thus limiting the opportunity to participate in crime (Nowacki, 2012).

Victimization

Being a victim of violence significantly increases the likelihood of becoming a perpetrator of violence (Corbin et al., 2013; Pizarro et al., 2011; Reed et al, 2010). Corbin et al. provided evidence that traumatic events experienced in childhood heighten the risk of becoming a victim or perpetrator of violence. African American males are especially vulnerable to being victims of violence (Goldman et al., 2011).

Homicide and African American Males

The homicide victimization and offender rate for African American men is the highest of any other group (Felson & Painter-Davis, 2012; U.S. Bureau of Justice Statistics, 2011). Homicide is the leading cause of death for African American males age 15-24 for the past 2 decades (Bridgewater, et al., 2011; CDC, 1990, 1991, 2010; Corbin et al., 2011; Copeland-Linder et al., 2010; Fingerhut, 1992; Jackson, n.d.; Johnson, 2004; Noguera, 2002; Rich, 2005; Sanders-Phillips, 1997). Homicide rates declined in 2000 to 5.5 per 100,000. In spite of that the number of young, African American murder victims increased (Fox, 2007). African American males have one chance in 146 of dying due to interpersonal violence (Partnership for Safety and Justice, 2004). An African American male has one chance in 21 of being murdered, this is in direct comparison to a one in 131 chance for White males (Jackson, n.d.; Washington, 1997). While African American males make up 6% of the total population in the U.S., African American males account for 34% of all murder victims (Jackson, n.d.).

Since 1990, several health objectives for the nation have focused on reducing the homicide rate among young people. Healthy People 2020 has among its objectives to

reduce firearm-related deaths to 9.2 per 100,000 population; reduce nonfatal firearm-related injuries to 18.6 per 100,000; reduce homicides to 5.5 per 100,000; and reduce physical assaults to 19.2 per 1,000 persons age 12 years and older (US DHHS, 2013). The homicide rate for young African American males between 1978 and 1987 was 73.1 per 100,000 (CDC, 1991). That rate had increased by 1987 to 84.6 per 100,000 (CDC, 1991). Firearms accounted for 78% of these homicides (CDC, 1991; Sanders-Phillips, 1997). This was consistent from 2001 to 2005, as 77% of homicides against African Americans were committed with a firearm (Harrell, 2007). From 1999-2007, the leading cause of death for African American males 15-44 continued to be homicide with 91.5 % committed by firearms (CDC, 2010). Firearms related homicide has been the leading cause of death for African American males 15 to 19 years of age in the U.S. since 1969 (Fingerhut, 1992; Webster, 1993). Felson and Painter-Davis (2012) pointed to evidence that African Americans are more likely to be victims of gun violence. Gun-carrying has been associated with the rise in homicides among African American youth which peaked in the 1990s (Spano, 2012). Survey data in 1990 reported the prevalence of carrying a gun was highest among African American and Hispanic males at 39% and 41% respectively (Webster, 1993). Firearm-related injuries have remained stable since the 1990s (Spano, 2012). The majority of homicides are committed using a weapon, usually a firearm (Fox & Zawitz, 2007: Pizarro et al., 2011). The motivation for carrying a gun varies. Multiple reasons exist for gun carrying reported by adolescents include protection (Felson & Painter-Davis, 2012; Spano, 2012), peer support of violence (Cao, 1997), and the acceptability of shooting someone (Webster, 1993). Homicide rates peaked in 1993,

at 79 homicides per 100,000 for African Americans (U.S. Bureau of Justice Statistics, 2011). However, the rate for African American males 18-24 years of age held at 91.1 per 100,000 in 2008 (U.S. Bureau of Justice Statistics, 2011). African American males aged 14-24 make up 16% of homicide victims and 27% of homicide offenders (U.S. Bureau of Justice Statistics, 2011). Health objectives since 1990 have been aimed at reducing the homicide rates among African American males.

The key epidemiologic features associated with the homicide rate for young African American males included firearm possession (Felson & Painter-Davis, 2012; Felson & Pare, 2010); being an African American male (Pizzaro et al., 2011); and the socioeconomic disparities between African American males and other male racial groups, alcohol and substance abuse, drug dealing, poverty, racial discrimination, and cultural acceptance of violent behavior (CDC, 1991; Horton, 2007; Lattimore, 1997). The areas with homicide rates greater than 100 per 100,000 accounted for the majority of homicide cases. This suggests that homicides against African Americans were more likely to occur in highly populated areas (Braga, 2003; CDC, 1991; Cubbin, 2000; Harrell, 2007). Boyle and Hassett-Walker (2008) found that at the neighborhood level high poverty rates are related to greater violence and victimization. Some recognized behaviors that can result in homicide are child abuse, rape, domestic violence and physical fighting among acquaintances (CDC, 1991).

African American males are disproportionately exposed to violence (Copeland-Linder et al, 2007; Felson & Pare, 2010). Witnessing community violence has been linked to substance abuse, anxiety, aggressiveness, depression, and antisocial behavior

(Corbin et al., 2011; Hammond & Arias, 2011). Even witnessing acts of violence significantly increases the risk of future offending (Duke et al., 2010) and psychological distress (Corbin et al., 2011; Hammond & Arias, 2011; Streets, 2011; Sturm, 2012; Shields et al., 2010). According to Shields et al., exposure to community violence often involves overlapping experiences of witnessing, victimization, hearing about violence, and perpetration. Over a lifetime, minorities are more likely to witness or hear about violence (Shields et al., 2010). Chen (2010) showed that 27% of African American adolescents reported being victimized or having witnessed violence in the past year. This is consistent with past research on exposure to violence in adolescents (Scarpa, 2003).

Exposure to Community Violence

Violence among adolescents and young adults continues to be a big problem in the United States and is taking its toll on the lives of young people. Since data were first recorded using the National Crime Victimization Survey (NCVS) in 1973, victimization rates related to violence have fluctuated (Scarpa, 2003). Rates have steadily increased since the mid 1980s (Braga, 2003; CDC, 1991; Fingerhut, 1992; Ousey, 2000; Thacher, 2000). Despite a decline in violent crime for all age groups, adolescents between 12 and 19 years remain at high risk for violence (Baxendale et al., 2012; Ellickson, 2000; Robinson et al., 2011; Singh, 1996). Violence involving guns is most common among this population (Braga, 2003; Felson et al., 2010; Felson & Painter-Davis et al., 2012; Fingerhut, 1992; Singh, 1996; Webster, 1993; Wells & Chermak, 2011).

Violence has been defined as an act causing emotional, psychological, or physical harm to individuals, communities or property (Washington, 1997). Violence includes

homicide, assault, abuse and battery, child physical and sexual abuse, child neglect, suicide, vandalism and any other form of property destruction (Washington, 1997). The number of assaultive violence is common especially among adolescent victims (Ellickson, 2000; Johnson, 2004; Richards, 2004; Scarpa, 2003; Sanders-Phillips, 1997). Assaultive violence refers to nonfatal and fatal interpersonal violence where physical force is used by a person to cause harm, injury or death to another (Sanders-Phillips, 1997). Ninety-seven percent of urban youth surveyed reported witnessing violent acts and 70% were victims themselves of some form of violence (Scarpa, 2003). Urban African Americans are more likely to be victims of violent crimes than Caucasians and suburban or rural African Americans (Goldmann, et al., 2011). In 2001, 5,385 youths aged 15-24 years died as a result of interpersonal violence in the U.S. (Johnson, 2004). The impact is even more dramatic for African American males. African American males aged 15-24 were 6.5 times more likely to die from homicide than white males the same age (Greenberg, 1992; Johnson, 2004).

Exposure to violence during adolescence can negatively impact physical and emotional health and the ability to form healthy relationships (Baxendale et al., 2012). It was found that adolescents involved in violent behavior were more likely to experience mental health, physical health, and economic problems as adults (Odgers et al., 2008). Other research showed an association between aggressive behavior as adolescents and victimization and perpetration as young adults (O'Donnell et al., 2009). Community violence refers to violence that occurs in communities or neighborhoods (Sanders-Phillips, 1997). Adolescents are often victimized by friends or acquaintances (Boyle &

Hassett-Walker, 2008; Hamblen, 2008; Sanders-Phillips, 1997; Scarpa, 2003;). Altercations can begin with physical fighting and then escalate to firearm injuries and homicide (Ellickson, 2000; Sanders-Phillips, 1997). It has been estimated that nonfatal assaultive injuries occur at least 100 times more often than homicides (Sanders-Phillips, 1997). It is more difficult to determine the exact number of injuries; but. it is estimated that 1.2 million acts of violence against adolescents go unreported. It is estimated that assaults involving adolescents are three times greater than arrest records show (Sanders-Phillips, 1997). Young African American males have higher rates of injury due to violence than any other groups (Hamblen, 2008; Sanders-Phillips, 1997).

Increasing rates of violence among African American males have been blamed on gangs. Although it is true that gang members commit more violent crimes than nongang members, they tend to be more prevalent among ethnic minority youth and often use weapons, particularly firearms (Sanders-Phillips, 1997), community violence impacts a broader range of people (Hamblen, 2008). A nationwide survey of boys and girls 10 to 16 years old conducted by Boney-McCoy and Finkelhor (1995) found 33% reported being the victim of violence that included sexual assault, aggravated assault, and kidnapping (Hamblen, 2008). Hill (1997) compared low-violence neighborhoods to high-violence neighborhoods revealed that 75% of the sample had witnessed acts of gang violence, stabbings, assaults, and homicide. In another study, 1,100 adolescents reported witnessing at least three different types of violence (Schwab-Stone, 1999).

Most community violence research has centered on high-risk children and adolescents (i.e. urban, low-income, minority; Scarpa, 2003). Few researchers have

explored community violence among young adults (Scarpa, 2003), even though violent crimes occur equally and in increasing rates among people over 18 years old. Patterns of homicide offending are similar to those of homicide victimization among African American adolescents and young adults (Miller & Bennett, 2011). Nearly 95.6% of respondents reported witnessing violence and 82% reporting being a victim of violence at least once in their lifetime (Scarpa, 2003). These findings are consistent with results from Goldmann et al. (2011) which found that 87% of African Americans had experienced at least one traumatic event in their lifetime and 51 % were victims of assaults. Similarly high prevalence rates of community violence were found for an ethnically diverse sample of urban young adults (Eitle, 2002). Exposure to community violence has been shown to be related to psychological distress, low academic performance, delinquency, and HIV-related risk behaviors for urban, minority adolescents (Voisin, Bird, Hardesty, & Shiu, 2011). Males have a tendency to be exposed to community violence more than females, especially gun violence (Voisin et al., 2011). African American males are more likely to be exposed to gun violence (Felson & Painter-Davis, 2012; Felson & Pare, 2010).

Boys are exposed to violence more than girls but report equal levels of distress related to direct victimization as girls (Voisin et al., 2011). Boys often report that peer influence is the most frequent cause of delinquency and that violence is motivated by retaliation (Copeland-Linder et al., 2012; Corbin et al., 2011; Rich & Grey, 2005; Robinson et al., 2011; Teevan, 2000). Coping styles may moderate the effects of exposure to violence for African Americans (Chen, 2010). There are few studies on how young people, particularly African Americans, cope with community violence (Voisin et

al., 2011). Confrontational coping has been linked to increased delinquency and impact of witnessing violence by boys (Voisin et al., 2011). Voisin et al. (2011) stated that one study found that negative coping was linked to PTSD symptoms. Avoidance, acceptance, and self-protection were coping mechanism for African American women exposed to community violence (Voisin et al., 2011). This may be the same for African American men, but there is little research on gender differences in coping styles. Violence may be a technique used by young African American males to maintain a certain self-image and to save face (Hall et al., 2008; Anderson, 1994). The pressure exists to show that a person is not to be messed with or risks being challenged by anybody or runs the risk of being viewed as weak (i.e. a sucker) by his peers (Anderson, 1994; Nowacki, 2012; Rich & Stone, 1996). A young African American man's self-image may be shaped by what he believes his peer group thinks of him (Anderson, 1994). The few studies on coping styles that exist fall short of providing a thorough understanding of the phenomenological experiences of African Americans exposed to violence (Voisin et al., 2011). This study will help fill the gap in the literature related to understanding the perspectives of African American men exposed to violence.

Theories

The causes of interpersonal violence among African American males are not yet completely understood (Washington 1997). Plausible causes include macho and compulsive masculinity, biological causes (e.g. brain injury), poverty, fragmented African American families, inadequate socialization, racial discrimination, displaced aggression, African American self-hate, adherence to a subculture that glamorizes

violence, the perception that African American life is worthless, and self-destructive lifestyles focused on alcohol and drug abuse (Oliver 1994; Washington 1997). Theories on the causes of interpersonal violence including homicide can be grouped into three categories: sociological, psychological, and environmental. Sociological theories focus on social factors like poverty, broken homes, and economic inequality (Reisig 2007). Psychological theorists asserted that psychological damage combined with low self-esteem, self-hatred, and rage result in violent behavior. Environmental theories suggest that cultural, historical, social, economic, physical and environmental factors produce stress associated with violence (Ammons 1997).

There are multiple theories that try to explain violence and aggressive behavior among African American males (Washington 1997). Three theories provide an explanatory framework for the cycle of violence and psychological impact experienced by many African American males: The subculture of violence theory (Wolfgang & Ferracuti (1967), the code of the street theory by Anderson (1994) and the pathways to recurrence model developed by Rich and Grey (2005).

Subculture of Violence

A subculture is a value system that transcends geographic places in a society (Cao, 1997). Subculture of violence theory (Wolfgang & Ferracuti, 1967) posits that a heterogeneous society will have a dominant culture with its own norms and values. In addition to the dominant culture, there will be a number of subcultures that may exist that each have its own norms and values that vary from the dominant culture. People are socialized to accept the different norms and values of a given subculture to which they

belong (Barlow, 1990; Wolfgang &Ferracuti, 1967). Within a subculture of violence there are cultural norms that produce, promote, and validate the use of violence (Ezell & Tanner-Smith, 2009; Wolfgang & Ferracuti, 1967). Since violence is an accepted form of expression within the subculture of violence, those immersed in that subculture are more likely to use violence to solve problems as well as experience more exposure and vulnerability to violent victimization (Ezell & Tanner-Smith, 2009). The subculture of violence theory maintains that criminal violence among African American men exists as a product of their adoption of a subculture that condones violence as an acceptable way to resolve conflicts (Cao, 1997; Cubbin, 2000; Ezell & Tanner-Smith, 2009; Washington, 1997; Teevan, 2000). This value system may be supported by peers increasing the likelihood that hostile impulses will lead to violence (Cao, 1997). Imbedded within the subculture of violence is the notion of compulsive masculinity. Compulsive masculinity suggests that there is a time in a young man's life when he turns away from identification with his mother in order to identify with what he views as masculinity (Teevan, 2000; Washington, 1997). Previously, he may have been greatly influenced by his mother, especially when the father is absent. To counteract the maternal influence, the young man behaves out of character resulting in compulsive masculinity. This concept has been applied to African American males to explain their expression of toughness, emotional detachment, independence, and sexual conquest (Irwin & Umemoto, 2012; Washington, 1997).

Code of the Street

The pervasive problem of interpersonal violence within poor inner-city African American communities is spawned from the unsavory conditions of daily life among the poor and lower socioeconomic class. A shortage of jobs that pay a living wage, racial stigma, the result of years of drug use and drug trafficking, and the alienation from mainstream society and hopelessness for the future is an environment that many young African American males find themselves (Anderson 1994; Hall et al., 2008; Sanders-Phillips 1997; Stewart & Simons, 2010). This environment puts them at special risk of violence exposure and victimization. While there are forces that can counteract negative influences such as a strong, loving family; despair has created a counterculture of "the streets" that opposes positive, protective factors and embraces negative risk factors (Hall et al., 2008; Nowacki, 2012). An opposition of these forces places young people in an environment where even those who reflect mainstream values have to act tough and fearless in order to be accepted by their peers (Anderson 1994; Hall et al., 2008; Nowacki, 2012).

Street culture has evolved into a system where violence is often used as a means to solve problems, especially in the African American community where the "code of the streets" often influences choices and actions (Anderson 1994; Ezell & Tanner-Smith, 2009; Rich 2005). Anderson (1994) defined the code of the street as informal, generally unspoken rules governing public behavior, including the use of violence (Corbin-Linder et al., 2012). The rules provide a context in how to respond when challenged (Anderson 1994; Joseph 1995; Stewart & Simons, 2010). African American youth raised in an

environment such as this are often encouraged to learn and operate under this code to survive the urban, poor environment (Anderson, 1994). The code of the street centers on the idea of respect and how African American males view respect and disrespect (Copeland-Linder et al., 2012; Nowacki, 2012). Respect and reputation are valued components of the social world of these youth (Nowacki, 2012). The person whose manner of dress, demeanor and way of moving (i.e. swagger) may provide him with a measure of respect (Anderson, 1994). Maintaining a level of respect is tenuous and must be continually guarded. Gaining respect may also be accomplished through physical attacks or by publicly disrespecting someone (Copeland-Linder et al., 2012; Nowacki, 2012). The instigator often gains respect at the expense of the defender. If the defender does not retaliate, he risks being the target of future attacks (Anderson, 1994; Copeland-Linder et al., 2012; Rich & Grey, 2005; Nowacki, 2012; Stewart & Simon, 2010). The threat or actual act of aggression is viewed as the worst form of disrespect (Rich & Stone, 1996; Rich & Grey, 2005). If a person can garner enough respect, he can avoid being "messed with" in public (Anderson 1994; Rich & Stone, 1996). If a person is *dissed* (i.e. disrespected) he may be in physical danger. Forms of dissing may be as petty as looking someone in the eye for too long. People become very sensitive to advances and slights, which could be warnings of imminent physical confrontation (Anderson 1994). Everyone living in disadvantaged areas does not subscribe to street-oriented behaviors but it is important to be aware of the street code to avoid violence or improve the outcome if violence cannot be avoided (Nowacki, 2012; Stewart & Simons, 2010). Victimization influences the adherence to street codes and adopting these codes increases victimizations

(Nowacki, 2012; Stewart & Simon, 2010). Males, particularly African American males, embrace the street code more than females who live in disadvantaged neighborhoods (Nowacki, 2012).

Anderson (1994) suggested that the code of the street manifests itself from the hostile context of poor African American neighborhoods and distrust in traditional forms of justice thereby contributing to violence and aggression among young African American males. Due to a deep sense of alienation from mainstream society and institutions felt by many poor young African American males, the code of the street becomes an adaptation to a lack of trust and confidence in the police and the judicial system (Copeland-Linder et al., 2012; Rich & Grey, 2005), this is often viewed as hostile toward African American males (Anderson, 1994; Liebschutz et al., 2010; Stewart & Simons, 2010). African American males in turn must protect themselves. Their ability to take care of themselves in the streets provides them with a certain type of deference, which gives him a sense of control (Anderson, 1994; Rich & Stone, 1996). The influence of drugs and access to guns aggrevates situations where African American males may feel disrespected (Anderson, 1994). This potentially creates situations where violence could be more likely to happen. The code of the street thesis provides a context for the pathways of recurrence model to explain the cycle of violence and reinjury among African American males who embrace the code of the street.

Pathways to Recurrence Model

Rich and Grey (2005) applied Anderson's (1994) framework of the code of the street to explain recurrent injury among African American men. Rich and Grey suggested

that the code of the street combined with traumatic stress and substance use set the stage for a hypothetical model of recurrent injury. According to this model, injury due to interpersonal violence upsets a person's feeling of safety in several ways. It elicits pressure to retaliate (Copeland-Linder et al., 2012, 2007; Stewart & Simons, 2010), reaffirms doubtfulness in the police (Rich, 2012), and creates traumatic stress symptoms (Rich & Grey, 2005). Since their sense of safety has been compromised, young men feel that they do not have many options to avoid dangerous situations and have to take matters into their own hands. This mentality often means initiating fights or carrying weapons (Corbin et al, 2011). Weapon carrying increases the risk of reinjury because it gives the victim courage to confront potential threats as well as for self-protection (Copeland-Linder et al, 2012). Complications associated with traumatic stress could include PTSD and hypervigilance (Corbin et al, 2013). Young males may resort to self-medication with illicit drugs or alcohol to deal with the symptoms of traumatic stress (Corbin et al., 2011; Rich & Grey, 2005). Hypervigilance may make routine situations seem more threatening than they really are. Both situations may contribute to recurrent violence (Rich & Grey, 2005).

The recurrent injury model is predicated on the code of the street concept characterized by Anderson (1994). Rich and Grey (2005) used this concept to study recurrent injury among African American male victims of violence. Anderson characterized the code of the street as informal rules that influence how a person should behave. The central theme of these rules is getting proper respect (Nowacki, 2012). It

demonstrates how many young African American males operate within these rules to assert and protect themselves (Rich & Grey, 2005).

"Rich and Grey (2005) theorized that Anderson's framework could explain recurrent injury among African American males. They studied African American males who had recently sustained violent injury. Rich and Grey developed a hypothetical theory of recurrent injury by investigating the relationship between traumatic stress, substance abuse and the code of the street. Victims, operating under the rules of the code and accentuated by substance use and traumatic stress, react in ways that potentially increase their risk of reinjury (Rich & Grey, 2005).

This theory suggests that exposure to violence and PTSD influences violent behavior in young African American males. Breslau et al. (1999) found that an association existed between exposure to violence and PTSD among urban adolescents. Those who were victims or witnessed acts of violence reported signs of PTSD (Corbin et al., 2013; Donley et al., 2012; Kelly et al., 2010; Scarpa, 2003). However, these researchers did not show a similar association for adolescents that live in rural areas or for African American males specifically. Nor did these researchers show how exposure to violence and PTSD influence violent behavior.

PTSD Origins, Symptoms, and Outcomes

PTSD, alternatively known as shell shock, traumatic war neurosis and gross stress reaction, was first identified in 1980 as a distinct psychological disorder when it was included in the third edition of the American Psychiatric Association's Diagnostic and Statistical Manual (Cameron, 1994). This disorder is often the result of experiencing or

witnessing a traumatic event that creates sensations of fear and anxiety (Donley et al., 2012). Considered to be a unique form of generalized anxiety, the DSM-5 outlines that any diagnosis of PTSD rests on four major criteria: (a) An individual has experienced a traumatic event that is either distinctly distressing or outside the range of normal human experience; (b) re-experiencing the traumatic event (Roberts et al., 2011) in the form of recurrent or persistent dreams, intrusive thoughts, and/or sudden flashbacks (Donley et al, 2012); (c) An individual avoids reminders of the event (Donley et al., 2012; Roberts et al., 2011); and (d) There is evidence of increased, persistent hyperarousal (Roberts et al., 2011) on the part of the traumatized individual in the form of anger, stress and/or irritability (American Psychiatric Association, 2013; Donley et al, 2012). Regardless of the particular stimuli that give rise to symptoms of PTSD, it has been found that PTSD is a disorder which often persists within the traumatized individual for years after the distressing event (Kessler, Sonnega, Bromet, & Hughes, 1995).

Much of the early research on PTSD involved military combat veterans and has been commonly associated as a possible consequence of war (Donley et al., 2012). With respect to the interrelationship between combat-related PTSD and aggression, previous investigations demonstrate that PTSD does indeed lead to violence (Gimbel & Booth, 1994). For example, research by McFall, Fontana, Raskind and Rosenheck (1999) discovered that veterans with combat-related PTSD were more likely to engage in a wide array of aggressive and violent behaviors, including interpersonal violence. Along these same lines, Byrne and Riggs (1996) discovered that veterans with PTSD were more likely to perpetrate acts of aggression and violence against their intimate partners. Other

research underscores these points by showing how combat-related PTSD leads to aggression and violence (Card, 1983; Gimbel & Booth, 1994; Solomon, Waysman, Belkin, Levy, Mikulincer and Enoch, 1992). Cynthia Gimbel and Alan Booth (1994) provide a persuasive argument that lends support to the previous statement:

> Actual participation in the violence and mayhem of combat may further distort the soldier's definition of appropriate and effective ways of dealing with others. Acts that are prohibited by civilian rules and values may become acceptable and even worthy of reward to combat veterans. The antisocial behavior may become a pattern that carries over to marriage. Moreover, the repeated trauma of combat may dull the individual's ability to perceive and respond in socially sensitive ways, causing him to become insensitive and abusive towards his marital partner. (Gimbel & Booth, 1994, p. 692)

Current Research

Civilian PTSD, which is associated with non-combat related trauma exposure, has received much less public awareness (Donley et al., 2012). However, current research is revealing high rates of trauma and PTSD among inner-city youths and adults (Donley et al., 2012). Roberts et al. (2011) found that African Americans showed higher lifetime prevalence of PTSD than other racial/ethnic groups and had a higher risk of developing PTSD after exposure to trauma. This is consistent with other samples of African Americans who exhibit disproportionately high rates of PTSD compared to Caucasians (Mokrue et al., 2011). A study of inner-city residents of Detroit revealed that those living in the inner-city experienced more violence and had twice the risk of developing PTSD

(Donley et al., 2012, Corbin et al., 2013). In another study, 65% of patients (n= 617) interviewed at Howard University Hospital in Washington, D.C., had experienced violence-related trauma and 51% met criteria for PTSD (Donley et al., 2012).

Causes of PTSD Among African American Males

Causes of PTSD among African American men may be similar as those for others who experience trauma. Factors known to increase risk for PTSD include exposure to combat and community violence (Kelly et al., 2010). Individual factors include being female, a history of mental health illness, being an ethnic minority, lower socioeconomic status, and a history of violence victimization (Kelly et al., 2010). However, there are racial/ethnic differences related to PTSD. According to Roberts et al. (2011), race/ethnic disparities in risk for PTSD can be attributed to two sources: (a) differences in exposure to traumatic events, and (b) differences in risk factors for developing PTSD. Trauma exposure varies by race and other demographics and factors that increase likelihood of trauma exposure may be different than the factors that increase vulnerability to the effects of the exposure (Roberts et al., 2011). Studies examining race/ethnic differences in PTSD and trauma exposure are limited by geographic area studied, event types, exposure to multiple events, age, generalizability to the larger population, and inconclusive or discrepant results (Roberts et al., 2011). In a study of race/ethnic differences in trauma exposure, PTSD development and treatment-seeking, it was found that trauma risk varied by type of event and African Americans had higher risk of witnessing domestic violence. The same study revealed African American men had higher risk of combat-related trauma

and African Americans had higher risk of PTSD as a result of trauma exposure (Roberts et al., 2011).

According to Kelly et al. (2010), many of the risk factors associated with PTSD are concentrated in urban city centers. Low income individuals living in urban areas have an increased risk of victimization and experience 60% more violent crimes than those living in the suburbs (Kelly et al., 2010). Urban residents experience more recurrent trauma (Kelly et al., 2010), which increases the risk of developing PTSD. Individual risk factors mentioned earlier increase the risk of post traumatic distress. Trauma experienced as a result of interpersonal violence and severe injury has been associated with the highest rates of chronic PTSD (Corbin et al., 2013; Kelly et al., 2010). In a study conducted at an urban trauma center of predominately African American men who were victims of gunshot wounds, showed that 75% of participants met criteria for PTSD (Corbin et al., 2013). Stressful life events which are common among urban adult victims of violence increases vulnerability to PTSD (Kelly et al., 2010).

Psychosocial Impact and Post Traumatic Stress

Understanding the context in which young African American males live and the aggression-related behaviors that are responsible for many of the assaults that happen among this group is key to understanding the psychosocial and behavioral impact on African American males (Cassidy, 2005). Community violence that involves serious injury to a person or elicits fear of being harmed can cause extreme psychological distress (Copeland-Linder et al., 2010; Kelly et al., 2010; Sanders-Phillips, 1997; Scarpa, 2003). Many children and adolescents in poor, urban neighborhoods are exposed to high levels

of violence on a constant basis (Corbin et al., 2013; Copeland-Linder et al., 2010; Oliver, 2000; Robinson, et al., 2011; Sanders-Phillips, 1997; Williams, 2002). Violence produces stress that is unpredictable, often occurs in public and impacts innocent bystanders (Oliver, 2000). High levels of community violence results in perceptions (real and imagined) of chronic danger. These perceptions have a cognitive, psychological, and behavior effect that influences daily life in communities where violence is pervasive (Kelly et al., 2010; Sanders-Phillips, 1997).

Victimization due to community violence may have a traumatic affect that is different from other events. It "involves issues of malevolence, betrayal, injustice, and morality to a much greater extent than other stressors and may involve social institutions like the police, courts, and social service agencies that are not involved in other types of trauma" (Sanders-Phillips, 1997, p.359). Adolescents exposed to community violence show greater emotional distress and antisocial behavior than adolescents who are not exposed to constant community violence (Copeland-Linder et al., 2010; Chen, 2010; Sanders-Phillips, 1997; Scarpa, 2003). Studies of children ranging in age from 6 to 12 years, found that children exposed to violence either as a direct victim or as a witness had higher ratings of distress and depressive symptoms including low self-worth, depressed mood, morose thoughts, and excessive crying (Chen, 2010; Freeman, 1993; Martinez, 1993). Boney-McCoy et al. (1995) also revealed findings of heightened distress, trauma symptoms and sadness among exposed youth. Further findings have found that increased antisocial behavior is associated with violence exposure (Miller, 1999; Schwab-Stone, 1999). Witnessing violence revealed a positive correlation with antisocial behavior

(Copeland-Linder et al., 2010) among children even after controlling for family variables such as parent-child conflict, minimal parental involvement, and minimal parental supervision (Miller, 1999). Violence victimization and witnessing violence was linked with behavior problems for adolescent males and females (Copeland-Linder et al., 2010; Schwab-Stone, 1999). Other effects of victimization seen in adolescents include stress, impaired judgment, low attention span, irritability, and loss of memory (Sanders-Phillips, 1997). Exposure to community violence appears to be an independent risk factor for depression, anxiety, and aggression in youth (Scarpa, 2003). Evidence for this was supported by Rosenthal (2000) who found that exposure to community violence as either a victim or witness during the high school years was associated with increased anger, anxiety, depression and detachment.

Chronic exposure to community violence has an impact on the emotional health of many African American youth and adults, of whom African American males are particularly vulnerable (Berton, 1996; Copeland-Linder et al., 2010; Donley et al., 2012; Hamblen, 2008; Kelly et al., 2010; Mokrue et al., 2011; Oliver, 2000; Rich, 2005; Scarpa, 2003; Sanders-Phillips, 1997). Scarpa found that individuals who experienced high levels of victimization or witnessing acts of violence reported PTSD symptomatology. Breslau (1999) asserted that an association between exposure to traumatic events and PTSD exists.

Oliver (2000) also stated that surveys of African American youth reveal that poor urban African American youth show signs of PTSD due to exposure to violence (Goldmann et al., 2011). The prevalence of chronic stressors like violence, intra-family

conflict, poverty, abuse, drug abuse and peer pressure may predispose urban adolescents to psychological stress and PTSD (Berton, 1996; Goldmann et al., 2011).

Diagnostic characteristics of PTSD include heightened emotional and physiological stress, re-experiencing fear-provoking thoughts, feelings and images of trauma and numbing of emotional responses (Donley et al., 2012; Oliver, 2000; Sanders-Phillips, 1997). Adolescents who have been witnesses or victims of violence may show a range of psychological symptoms related to PTSD (Sanders-Phillips, 1997). Adolescents experiencing PTSD symptoms may become depressed, angry, distrustful, fearful and withdrawn (Hamblen, 2008; Sanders-Phillips, 1997). Young victims of violence can report feeling that they have no future and fear they will not reach adulthood (Hamblen, 2008; Sanders-Phillips, 1997). Adolescent victims may experience feelings of helplessness, hopelessness, self-blame, and retaliation (Berton, 1996; Roberts et al., 2011; Sanders-Phillips, 1997; Teevan, 2000). Behaviors such as acting out, risk taking, self-destructive behavior, passivity, emotional detachment, difficulties learning, running away, suicide attempts, drug use, and increased sexual activity are all associated with community violence victimization (Baron, 1999; Brook, 1997; Copeland-Linder et al., 2010; Hamblen, 2008; Sanders-Phillips, 1997). Chronic exposure to community violence also has the effect of desensitizing youth to the threat and consequences of violence resulting in more risk taking and increased confrontations (Sanders-Phillips, 1997).

Repeated exposure to violence also increases the likelihood of victimization or commission of violence by creating a sense of vulnerability and the belief that violent victimization is normal (Sanders-Phillips, 1997). These feelings are particularly

pronounced among poor urban adolescents, especially young African American males and could explain the high recurrent victimization among this population.

Rich and Grey (2005) applied Anderson's (1994) framework of the code of the street to explain recurrent injury among African American men. Rich and Grey suggested that the code of the street combined with traumatic stress and substance use set the stage for a hypothetical model of recurrent injury. Rich and Grey found that two third of their study participants met the criteria for PTSD as well as hypervigilance (i.e. exaggerated awareness of danger). Rich and Grey hypothesized that PTSD played a role in recurrent injury among African American men.

African American youth are at a higher risk of being a witness to the murder of a friend or relative or being a victim of violence than other groups (Berton, 1996; Sanders-Phillips, 1997). In a study of violence exposure among African American youth, Fitzpatrick (1993) found that 27% of a sample of 199 participants met all three of the criteria for PTSD. A significant number of African American youth who live in neighborhoods where they are subject to chronic community violence exposure show symptoms of PTSD (Oliver 2000). Much of the research related to violence exposure and PTSD has been done on children and adolescents (Berton, 1996; Fitzpatrick, 1993; Hill, 1997). Berton found that African American males are exposed to more violent crimes in their neighborhoods and schools than white males. African Americans are exposed to more violence and are more likely to be victims than Caucasian Americans (Berton, 1996; Oliver, 2000; Harrell, 2007; Richmond et al., 2011). Males are victimized more than females (Flannery et al., 2006). Breslau et al. (1991) reported the incidence of PTSD

among urban adolescents exposed to traumatic events to be 23.6%. A search of the literature revealed few studies that reported the incidence or prevalence of PTSD specifically among African American males. One of the few studies on lifetime prevalence of PTSD found it to be highest among African Americans (Roberts et al., 2011). Researchers revealed that among the risk factors for PTSD previous exposure to traumatic events, low educational level, and being African American pose the greatest risk for developing PTSD symptoms (Breslau, 1995, 1999). Few researchers have examined the psychological effects of assaultive violence on adolescents despite increasing rates of violence, particularly among African American males (McGruder-Johnson et al., 2000; Breslau, 1992, 2001, 1999, 1991, 2004; Collins, 1990; Fehon, 2005; McGee, 2001; Rich & Sullivan, 2001). There is also scant literature on the relationship between PTSD and subsequent violent behavior (Begic & Jokic-Begic, 2002; Breslau 1999; Collins, 1990; Donley et al., 2012). Donley et al. suggested that research has not determined if civilian PTSD is associated with higher levels of violent behavior among inner-city adult populations. Donley et al. revealed that trauma exposure and civilian PTSD are associated with increased involvement in violent offenses among inner-city residents. It is not understood if this association is true for African American men. To address this gap in the literature, my research seeks to describe the effects of violence exposure and PTSD among a sample of young adult African American males.

Hypervulnerability and Hypermasculinity

According to Cassidy (2005), African American males particularly in poor urban environments may exhibit increased hypermasculine behavior associated with aggression

(Livingston, 2006). Hypermasculinity is defined as attitudes and behaviors that reflect feelings of aggression, danger-seeking, and callous attitudes toward women (Cassidy, 2005). Cassidy further stated that African American males exaggerate their hypermasculinity and behave aggressively to cope with the vulnerability and powerlessness they feel in their daily lives (Watkins et al., 2010). Hypermasculine behavior is consistent with Andersen's code of the street thesis (Anderson, 1994; Nowacki, 2012). African American males may exhibit toughness and aggressiveness to win respect and status (Anderson, 1994; Nowacki, 2012; Rich & Grey, 2005). The vulnerability that African American males living in urban environments experience may include feelings of depression, rejection, and fear all of which have been associated with aggressive behavior in adolescents (Cassidy, 2005). Cassidy revealed that few researchers have focused on the relationship of depression, rejection and sensitivity to aggression in adolescent African American males. Cassidy concluded that aggressive behavior in young African American males serves as a reactive coping strategy to hide vulnerabilities that were characteristic of depression, rejection, sensitivity and fear.

Victims of interpersonal violence may experience hypervigilance as a symptom of post traumatic stress (Corbin et al., 2013). Corbin et al. stated that qualitative research shows that symptoms like hypervigilance may lead victims of violence to feel vulnerable and engage in behaviors, like weapon carrying, that increase the risk of re-injury (Corbin et al., 2013). Addressing hypervigilance has been identified as a topic of interest in future interventions aimed at reducing violent behavior among African American men (Rich & Grey, 2005; Watkins et al., 2010).

Critique of Methods

The researchers who have been cited in the literature review have all investigated aspects of violence and PTSD. Much of the research has focused on children and adolescents in urban centers (Berton, 1996; Fitzpatrick, 1993; Hill, 1997). There are few studies on how young African American males, cope with community violence (Voisin et al., 2011). The ones that do fall short of providing a thorough understanding of African Americans experiences with violence (Voisin et al., 2011).

Further limitations in the studies cited in the review that investigated PTSD revealed that studies examining race/ethnic differences in PTSD and trauma exposure are limited by geography, events, multiple exposures, age, generalizability, or inconclusive results (Roberts et al., 2011). Several researchers have shown an association between exposure to violence and PTSD among urban adolescents. (Breslau et al., 1999; Corbin et al., 2013; Donley et al., 2012; Kelly et al., 2010; Scarpa, 2003). However, these researchers did not provide evidence that a similar association for adolescents that live in rural areas or for African American males exists. These researchers did not show how exposure to violence and PTSD influence violent behavior. It is not clear from the literature in this review what the incidence and prevalence of PTSD is among African American males. There is also little literature on the relationship between PTSD and subsequent violent behavior (Begic & Jokic-Begic, 2002, Breslau 1999; Collins, 1990; Donley et al., 2012). It has not been determined if there is an association between civilian PTSD and higher levels of violent behavior among inner-city adult populations (Donley et al., 2012).

Most of the studies cited in this review have used either a quantitative or qualitative design. The mixed-methods approach I will be using in my study will verify the results of the quantitative components by converging the qualitative portion of the methodology providing stronger evidence for conclusions derived from the results. The quantitative results will be matched with the themes generated by the qualitative results. Many of the qualitative studies found in this review use small sample sizes, which makes generalizing the results to the larger population difficult. Using a mixed-methods design increases the generalizability of the results. A mixed-methods approach allows for a broader range of research questions to be answered. The inclusion of qualitative interviews adds insights and understanding that might otherwise be missed if only a single method is used.

Summary

This chapter was an overview of the problem associated with the effects of exposure to violence and PTSD on African American men who are victims or witnesses of violence. Consistent themes in the literature are African American men are disproportionately affected by violence; African American males who live in low-income, urban environments are at a higher risk of witnessing violence and perpetrating violence. The literature further confirmed that African American males are at an increased risk of developing PTSD due to exposure to violence and they are underserved in the area of mental health services. Gaps in the literature fail to explain what aspects of being African American and male influence poor mental health outcomes (Watkins et al., 2010). The literature does not provide any clarity on whether or not PTSD explains

violence perpetration among African American males. Subculture of violence, Anderson's code of the street thesis and the pathways to recurrence model were explored as possible theories for the causes of interpersonal violence among African American males. Finally, the psychosocial impact of violence as well as the potential role of PTSD on recurrent injury due to subsequent violent behavior is examined. Chapter 3 is a detailed description of the methodology that will be used to address the research questions and gaps identified in the previous chapters.

Chapter 3: Research Method

Introduction

This chapter is an explanation of the mixed method approach used to analyze the experiences of African American men exposed to violence. The research methodology will be described as well as sampling techniques. The role that I played in the study will be presented. Instrumentation and data collection techniques will be discussed, including threats to internal and external validity. The ethical protection of participants will be described. Data analysis strategies will be discussed.

Research Design

I used a mixed methods methodology this study. Mixed methods inquiry employs data collection and analysis from both quantitative and qualitative methods (Creswell, 2003; Ulin et al., 2005). Combining both approaches in one study may result in a much stronger design by converging or confirming results from different, concurrently collected data sources (Ulin et al., 2005).

The qualitative approach was appropriate to answer Research Questions 1 and 2. The qualitative research questions in this study were:

Qualitative Research Question 1. What are the experiences of young African American men who are exposed to violence?

Qualitative Research Question 2. What are the influencing factors associated with recurrent violence among young African American males?

Ulin et al. (2005) contended that qualitative methods help the researcher to understand underlying behaviors, attitudes, perceptions, and culture. Qualitative methods

are naturalistic, applying to real-world circumstances as they naturally unfold (Ulin et al., 2005). It is a systematic process of discovery that allows the researcher to understand social processes and what they mean to people. Patterns of shared experience can be gleaned from qualitative methods (Ulin et al., 2005). Data were collected using open-ended, semistructured interviews. Similar qualitative methods have been used by researchers investigating the relationship between trauma, culture of violence, violence exposure, and youth violence (Bridgewater et al., 2011; Rich & Grey, 2005; Voisin et al., 2011).

The approach employed in this study was phenomenological. Phenomenological research is concerned with capturing the essence of human experience regarding a specific phenomenon through the eyes of the participants in the study (Creswell, 2003, p.15). A quantitative survey design offers a description of trends, attitudes or opinions of a population using numbers by studying a sample of that population. The findings allow the researcher to make generalizations about the population (Creswell, 2003). Quantitative methods were used to measure PTSD symptoms using the PTSD-Checklist and past acts of violence using the Past Feelings and Acts of Violence (PFAV) survey. Quantitative methods have been used by Rich (2012) and Rich and Grey (2005) to measure PTSD and exposure to violence in their research on African American males. Quantitative methods answered the following research questions:

> Quantitative Research Question 3. What is the relationship between PTSD-like symptoms and African American men who have experiences (as a victim or witness) with interpersonal violence?

H_0: African American men who have experienced interpersonal violence will not report PTSD symptoms as evidence by scores on the Post Traumatic Checklist-Civilian (PCL-C).

H_A: African American men who have experienced interpersonal violence will report PTSD symptoms as evidenced by scores on the Post Traumatic Checklist-Civilian (PCL-C).

Quantitative Research Question 4. To what extent is there an association between PTSD symptoms and violent behavior among African American men?

H_0: African American men who exhibit PTSD symptoms will not report past acts of violent behavior as evidenced by scores on the Past Feelings and Acts of Violence (PFAV) Questionnaire.

H_A: African American men who exhibit PTSD symptoms will report past acts of violent behavior as evidenced by scores on the Past Feelings and Acts of Violence (PFAV) Questionnaire.

Setting and Sample

The sample was drawn from African American males who were between the ages of 18 and 24. A broad sample of men in an urban setting from a city in Eastern North Carolina was recruited from areas where there were high community violence rates as identified by police crime data. The setting was relevant to the study for locating eligible participants who experience the phenomena of interest.

The sample size was estimated using Cohen's d for an effect size of 0.30 for the test of significance of the sample, assuming a statistical power of 0.80 and an alpha level

of .05 (Cohen, 1992). These values were selected to plan the study in such a way that the size of the sample was sufficient to show that the effect on the results was due to the study and not external factors or chance (Creswell, 2003). Using Cohen's tables and a sample size calculator to determine necessary sample size, the sample for this study was determined to be N=385 participants.

According to Burkholder (2005), statistical power is the probability that an effect will be detected. The level of power determines how likely the study is to avoid Type II error (Rudestam & Newton, 2007); a Type II error happens when the results fail to reject the null hypothesis which suggests that some effect existed that the study did not detect. High statistical power improves the study findings by decreasing the probability that the results are due to only chance. The accepted value for statistical power is 0.80. This means that given the sample size the study would be able to detect a treatment effect (or mean difference) 80% of the time (Burkholder, 2005); an alpha level of .05 is generally accepted. It means that there is a 95% chance of arriving at the right conclusion (Burkholder, 2005).

A purposive sampling strategy was used to recruit participants. The participants were recruited via flyers. School resource officers, health professionals from local hospital emergency department, social workers, and law enforcement were asked to share the study flyer with their clients. Study participants were recruited until the desired sample size was achieved. Flyers were placed in convenience stores, community recreation centers, and barbershops within and around high crime areas (Appendix E).

The flyers gave a brief description of the study and how to contact the researcher if interested in participating. Snowball sampling was also used to locate additional participants after an initial participant had been recruited. Snowball sampling is a technique in which the researcher first identifies someone who meets inclusion criteria and then asks each participant to recommend others (Ulin et al., 2005). The criteria for participation were that the participants be African American males age 18-24 years and that they self-report that they had been a victim, witness, or perpetrator of interpersonal violence.

This age range was selected because the literature states that African American males between the ages of 15 to 24 have the highest homicide rates (Rich & Grey, 2005; Rich & Sullivan, 2001; Rich & Stone, 1996; National Center for Injury and Control, 2007). According to the National Crime Victimization Survey (2010), people 25 years of age and older are victimized at lower rates than younger people (Truman, 2011). Hashima (1999) found that adults 18 to 24 were victimized at the same rate that youth aged 12 to 17 had been victims of violence.

People between the ages of 18 to 24 had the highest rates of violent victimization by strangers between the years 2005-2010 (Harrell, 2012). Participants were adults at least 18 years of age. The only exclusion criteria were males under 18 years old, males who did not self-identify their ethnicity as being of African American descent, individuals who were not able to provide consent, and those who had not been a victim or witness of violence were not be selected for this study. Participants selected to be interviewed consisted of five to 10 men from a purposive sample of African American

men who had experience with violence. Phenomenological studies often engage a relatively small number of participants (Creswell, 2003; Rudestam & Newton, 2007).

Measures

Post Traumatic Checklist

Participants filled out questionnaires that included information on demographics, violent behavior, and PTSD symptoms (Post-traumatic Checklist-Civilian). PTSD symptoms was assessed using items adapted from the PTSD checklist civilian version (PCL-C; Weathers, 1994). This was a 17-item standardized self-report rating scale for PTSD that corresponds to significant symptoms of PTSD (Weathers, 1994). There are two versions of this instrument. One is specific to PTSD related to military experiences and the civilian version that can be applied to any traumatic event in general. The civilian version was used in this study. Respondents will self-report how they have been affected by a symptom over a certain time period (e.g. in the past 12 months) using a 5-point scale. Responses for this scale can range from 1 (*not at all*) to 5 (*extremely*). This instrument has been shown to be both valid and reliable (Blanchard, et al., 1996; Campbell, et al., 1999; Weathers, 1994). The PCL-C is composed of items that correspond to the DSM-IV criteria for PTSD (Ruggiero, et al., 2003). The PCL-C has strong internal consistency and good test-retest reliability with Cronbach alpha coefficients ranging from 0.94 – 0.96, (Mokrue et al., 2011; Ruggiero et al., 2003). Scores from the PCL-C correlate highly with well-established measures for PTSD providing support for convergent and discriminant validity for this tool as well as strong predictive validity on a diagnostic level (Ruggiero et al., 2003). A total severity score

was calculated as an indicator for key symptoms of PTSD. The PTSD checklist can be found in Appendix A.

Past Feelings and Acts of Violence

Violent behavior was measured using the PFAV scale developed by Plutchik and van Pragg (1990). The self-report PFAV scale will measure violence risk and propensity for violence of the study participants. This is a 12 item, self-report measurement tool. Responses range from *never* to *very often* and *never* to *more than twice*. A total score was calculated by summing the responses and weighting from 0 to 3 with *never* equal to 0; *sometimes* and *once* equal to 1; *often* and *twice* equal to 2; and *very often* and *more than twice* equal to 3. According to Suris et al. (2004), this instrument has demonstrated psychometric qualities. This instrument has been shown to have an internal consistency coefficient alpha reliability of 0.77 (Plutchik & van Praag, 1990; Suris, 2004). The PFAV can be found in Appendix B.

Open-Ended Interviews

Open-ended questions about exposure to violence, violent behavior, PTSD symptoms, and injury were asked. After completing the questionnaires, participants were interviewed. The purpose of the interviews was to collect data about individual-level, contextual factors related to assaults and to gain a better understanding of the experiences the participants have with violence. Open-ended interview questions were adapted using questions from three existing tools found in the PsycTests database that measure exposure to violence: The Community Experiences Questionnaire (Schwartz & Proctor, 2000); the Community Violence Exposure Survey (Saltzman, Layne, & Steinberg, 1998)

and the Exposure to Violence and Criminal Behavior on the Streets Questionnaire (Kipke et al., 1997). The Community Experiences Questionnaire (CEQ) is a 25 item self-report measurement tool of children's exposure to violence. It has two subscales measuring victimization and witnessing. The subscales for victimization and witnessing exhibited strong psychometric properties with Cronbach alphas of 0.81 and 0.89 respectively. Internal consistency was established through consultation with school teachers to ensure comprehension (Schwartz & Proctor, 2000).

The Community Violence Exposure Survey (CVES) is a 25 item self-report inventory of community violence exposure. Exposure to violence is assessed by identifying endorsements of several types of trauma exposure. Both the CEQ and CVES have been adapted from the Survey of Exposure to Community Violence by Richters and Saltzman (1989) which has been a widely used measure of violence exposure. The Exposure to Violence and Criminal Behavior on the Streets Questionnaire was developed to assess violence exposure of homeless youth between the ages of 13-23. This instrument has been used in a study by Kipke et al. (1997) to assess victimization, perpetration, witnessing violence and fear experienced by homeless youth. The duration of the interviews will not exceed 90 minutes.

Before interviews were conducted with the larger sample population, the interview instrument were pilot tested. Interview questions were reviewed by members of the target population who meet the same study inclusion criteria as the main study as well as professional peers to ensure the tool is well-constructed. After the instrument had been tested, if any adjustments were made a revised instrument was submitted to the

Institutional Review Board (IRB) for approval before data collection began. The interview questions are listed in Appendix C.

Data Collection and Analysis

Data Collection occurred in two phases. Phase 1 was the quantitative portion. During Phase 1, participants completed an online questionnaire. The consent form was included on the questionnaire. No signature was required for consent. After reading the consent form, if participants agree to participate they will proceed by checking "yes" and complete the questionnaire. Completion of the questionnaire indicates consent. If participants choose not to participate, they will select "no" and the online questionnaire ends. Quantitative data was collected from responses to the 12-question PFAV questionnaire and the 17-item PTSD Checklist. Descriptive statistics were presented from the quantitative data.

The PFAV is a 12 item self-report questionnaire designed to measure the respondents' risk of violence. The PFAV has 4 point Likert-type scales ranging from never to very often and never to more than twice. Scoring was computed by summing the responses for items 1-11. Item 12 required a yes/no response and called for frequencies. The average number of times reported for each item will provide continuous data for quantitative analysis. The PTSD checklist is a 17 item self-report scale that corresponds to the key symptoms of PTSD. Respondents indicate how much they are bothered by a symptom in the past month. Responses were based on a 5-point (1-5) scale ranging from *not at all* to *extremely*. Scoring was computed by summing all the items to calculate a total severity score. The dependent variable in this study was violent behavior. The

independent variables were PTSD symptoms and exposure to violence. Regression analysis will describe the odds of violent behavior when exhibiting PTSD-like symptoms while controlling for race, gender, employment status, income, marital status and educational level. Violent behavior is operationalized as involvement in physical fights, stabbings, and involvement in shootings (i.e. being shot, being shot at or shooting at someone). A Pearson correlation test was performed to examine the relationships between violent behavior as evidenced by responses to the PFAV questionnaire and PTSD-like symptoms evidenced by the PTSD checklist. The researcher will collect the questionnaires and score them. Quantitative analysis was performed using SPSS software.

Table 1

Quantitative Analysis

Research question	Variables	Level of measurement	Type of analysis
Research Question 3: What is the relationship between PTSD-like symptoms and African American men who have experiences (as a victim or witness) with interpersonal violence? H_0: African American men who have experienced interpersonal violence will not report PTSD symptoms as evidence by scores on the Post Traumatic Checklist-Civilian (PCL-C). H_A: African American men who have experienced interpersonal violence will report PTSD symptoms as evidenced by scores on the Post Traumatic Checklist-Civilian (PCL-C).	PTSD symptoms Interpersonal violence	A total severity score calculated as an indicator for stress. This is a 5-point Likert scale 1 (not at all) to 5 (extremely)	Pearson correlation
Research Question 4:To what extent is there an association between PTSD symptoms and violent behavior among African American men? H_0: African American men who exhibit PTSD symptoms will not report past acts of violent behavior as evidenced by scores on the Past Feelings and Acts of Violence (PFAV) Questionnaire. H_A: African American men who exhibit PTSD symptoms will report past acts of violent behavior as evidenced by scores on the Past Feelings and Acts of Violence (PFAV) Questionnaire.	Violent behavior PTSD symptoms	A total score was calculated using this tool. The responses range from never to very often (ordinal). There is one question that is yes/no (nominal).	Logistic regression Linear regression

Phase 2 involved the qualitative portion. During Phase 2, I contacted participants for interviews. A subset sample of participants who show any PTSD-like symptoms and past acts of violence from their questionnaire responses were contacted for interviews. Since the qualitative portion of the study employs a phenomenological approach, a small number of participants was selected for interviews. Rudestam and Newton (2007) recommend five-10 participants. Interviews took place in a neutral location convenient to the participants that ensured privacy. Interviews were digitally recorded and transcribed. Additional field notes were taken to document any nonverbal communication and any other details related to the study environment. Once interviews were complete, data was organized into files of transcribed interviews. Files, recordings, and field notes are stored in a locked filing cabinet in the researcher's home office for a time period mandated by the Walden University IRB. In addition to items mentioned above, my role was to obtain authorization to conduct the study from the IRB.

The first step in the data analysis involved organizing the data. The interviews were transcribed and typed. The data were sorted and arranged in types or groups according to the sources of information. Any identifiable information was destroyed after transcription was completed.

The next step was to read the data thoroughly to gain an understanding of the information. Specific statements were highlighted that were relevant to the issues being studied. These statements were used to identify patterns and important themes. Redundant or overlapping statements were removed, leaving the key meaning units (Rudestam and Newton, 2007). The coding process was next. Coding is a process that

involves organizing the data into clusters before assigning meaning to those clusters (Creswell, 2003). The text data were labeled and grouped into categories. The themes identified were shaped into a general description of the phenomenon being studied from the participants' point of view. Finally, the individual descriptions of the participants' experiences with violence were clustered to form a composite description that represents the experiences of the group as a whole. This composite description will provide a better understanding of the experiences of African American men with regard to interpersonal violence. I used CyberLink software to perform qualitative data analysis. The software was used to create themes and sort written documentation.

Internal and External Validity

The qualitative research findings from this study were verified using strategies common in qualitative studies. There are eight primary strategies that can be used to verify the accuracy of findings. Creswell, (2003) recommended discussing one or more procedures that entail either "triangulation, member-checking, rich and thick description, clarifying researcher bias, negative or discrepant information analysis, persistent, prolonged observation, peer debriefing, or external audits" (pp. 196-197).

Triangulation was used to combine the quantitative and qualitative components of the study. Relationships between the scales of the PCL-C and PFAV were compared to qualitative data identified from responses to the interview questions to corroborate quantitative results. I used member checks, clarifying researcher bias, and rich, thick description to verify findings. The participants served as checks throughout the data collection process. Member checking is a process of determining whether the participants

feel that the findings and interpretations are accurate (Creswell, 2003). A continual dialogue occurred between me and the participants. My interpretations of the participants' reality and meanings were checked by asking the participants if I have captured the essence of their responses as they see it.

Clarification of researcher bias is important in this proposed study. Self-reflection on the researcher's position in regards to the study topic "creates an open and honest narrative that will resonate well with the readers" (Creswell, 2003, p. 196). The researcher in the proposed study shares the same race/ethnicity of the study participants. I have experienced interpersonal violence and increased stress and anxiety as a result. I am aware of my experiences and believe this enhances my awareness, knowledge and sensitivity to the challenges, decisions and issues facing African American men who experience violence.

Finally, the use of rich, thick, detailed description was employed to convey findings. The purpose of detailed description allows the reader to be "transported to the setting and give the discussion an element of shared experiences" (Creswell, 2003, p. 196). Verbatim transcripts with descriptive information was provided. Strategies used in data collection and analysis were reported in detail. All phases of the research process were subject to scrutiny by the dissertation committee.

Protection of Participants

Participants in this study are free to participate and can withdraw at any time. There are no known threats of harm associated with participating in this study. However, since traumatic stress was examined, every participant received a referral list of local

mental health services and substance abuse treatment centers as well as where to go to get more information on PTSD. I have a relationship with local mental health providers and will facilitate referrals for those who meet the criteria for PTSD-like symptoms and may need follow-up care. To protect participants, the research proposal was reviewed by the Walden University IRB to ensure that proper measures are in place to protect the welfare of participants. I obtained consent and participants completed an informed consent form. The informed consent explained the purpose of the study. It also informed the participant who was conducting the study. The consent explained why the participant has been selected to participate and the time commitment for participating.

Participation was completely voluntary. Participants' identities were anonymous and the data collected was held confidential. Participants were assigned an identification number to ensure anonymity. For example, a 19 year old African American male participant was identified as MB19. If there are two males with the same code there was a parenthesis placed after the code indicating the participant number. For example, the same coded male that replicated the previous example was coded MB19 (2). Files, audiotapes, transcripts and the interview guides are stored in a locked file cabinet located in my home. Any identifying information was removed from study documents prior to data verification. Only I will have access to study documents. A copy of the informed consent is attached in Appendix D.

Summary

This chapter was an overview of the mixed methods approach that was used in this research. This chapter was a description of the research questions, the research

design, sampling and data collection procedures. There are two qualitative research questions and two quantitative questions. Purposive and snowball sampling was used to recruit participants. The study participants were African American males between the ages of 18 to 24 who have experienced violence as either a victim or witness and can provide consent to participate in the study. Data was collected using the Post traumatic checklist to assess PTSD. Violent behavior was measured with the PFAV. A subset of participants was interviewed using the qualitative interview questions instrument to collect contextual data on the lived experiences of the participants with violence.

The validity and reliability of the study as well as the instruments used is provided. The instruments used in the study were adapted from validated existing tools. The interview questions were piloted tested prior to data collection to ensure the instrument is appropriate to answer the research questions. Finally, ethical considerations for study participants and the data analysis process are also presented. The study proposal was reviewed by the IRB to ensure the welfare of participants and that ethical standards are met. Chapter 4 includes details of the data analysis and results.

Chapter 4: Results

Introduction

The purpose of this study was to examine the impact of PTSD on young African American men who have had experiences with violence. This chapter is a description of the data collection methods, data analysis and a summary of the results. Two quantitative and two qualitative research questions were addressed:

Qualitative Research Question 1. What do young African American men who are exposed to physical violence as either perpetrators and/or victims think about their exposure to violence?

Qualitative Research Question 2. What do young African American males think are the primary factors associated with recurrent exposure to violence?

Quantitative Research Question 3. What is the relationship between PTSD-like symptoms and interpersonal violence among African American men who have been either a victim or witness of violence?

Quantitative Research Question 4. To what extent is there an association between PTSD symptoms and violent behavior among African American men?

In this chapter, the data collection and analysis processes are discussed including how the data were collected. The steps involved in analyzing the data will be described. Finally, a detailed discussion of the results will be presented.

Data Preparation

Prior to all statistical analyses of the quantitative data, it was determined that the analyses should only be conducted on individuals who (a) provided complete responses

with respect to all questions in the survey, and (b) met the criteria for inclusion within the study. In other words, only individuals who had valid data points for all of the questions asked were included in the final dataset. There were a total of 372 individuals who initiated participation within the survey. Of these individuals, only 353 met the aforementioned inclusion criteria. The final sample used for purposes of all data analyses was 353 completed surveys. The difference between the total number of individuals who initiated the survey and the total number of completed surveys is 19. This difference represents a 5.1% attrition between the total number of individuals who initiated participation within the survey and those individuals who were retained within the final dataset.

The G*Power 3.1(Faul, Erdfelder, Buchner, & Lang, 2009) program was used to compute a power estimation prior to the computation of all inferential statistics. As Faul et al. noted, a power test is used to determine the optimal sample size necessary to detect statistically significant effects in a sample that is drawn from a given population. A significance level of 0.05, a power of 0.95, and a medium correlation of 0.3 for an a priori bivariate correlation model estimate yielded a sample size of approximately 115 needed to satisfy the requirements of the statistical model. The sample of 353 is more than enough to satisfy the parameters outlined by the G*Power analysis.

Two variables were recoded as part of this investigation. The variable that asked respondents to indicate their marital status was collapsed into a dichotomous indicator as a function of its distribution of scores. The most often selected choice for this variable was “never married”; as such, this variable was recoded as either “never married” or

"other". The variable that asked respondents to indicate their employment status was also collapsed into a dichotomous indicator as a function of its distribution of scores. The most often selected choice for this variable was "student"; as such, this variable was recoded as either "student" or "other". It should also be noted that 47 respondents elected to respond "prefer not to say" when asked about their income. Given the continuous distribution of this variable, mean substitution for these missing data was used as a way of situating the missing data within the original distribution of scores. Allison (2002) notes that mean substitution is an appropriate substitution strategy when replacing missing data. Although there is no established cutoff within the existing literature concerning the proportion of missing data that can be imputed, it is generally accepted that imputation is allowable provided that the data is missing at random (Allison, 2002; Dong & Peng, 2013). The data for the variable income were with no discernable pattern (i.e., at random); as such, mean imputation for missing data is preferable to the list-wise deletion of cases (Allison, 2002).

Research Questions, Variables Used and Statistical Techniques Used

Descriptive statistics (Table 2) in the form of means and standard deviations (Table 3) for the two scales used in the current project (i.e., the Past Feelings and Acts of Violence (PFAV) scale and the Post Traumatic Checklist-Civilian (PCL-C) scale) and the variable which measured income, as well as percentages and frequencies for the categorical variables used in the current project (i.e., the marital status, age, employment status, educational level and location where a respondent lives) were computed so as to articulate the basic patterns within the data. Reliability estimation of the two scales used

in the current project (i.e., the PFAV and the PCL-C) was demonstrated via the computation of Cronbach alpha estimates (Table 4). Each of these statistical procedures is detailed below.

Descriptive Statistics

Table 2

Percentages and Frequencies, Study Variables

	Frequency	Percent
Biological sex of respondent		
Male	353	100.0%
Female	0	0.0%
Race of respondent		
African American	353	100.0%
Non-African American	0	0.0%
Marital status of respondent		
Never married	123	34.8%
Other	230	65.2%
Age of respondent		
18	32	9.1%
19	39	11.0%
20	55	15.6%
21	47	13.3%
22	50	14.2%
23	62	17.6%
24	44	12.5%
25	24	6.8%
Employment status of respondent		
Student	79	22.4%
Other	274	77.6%
Location of respondent		
City	284	80.5%
Suburb	30	8.5%
Small town	29	8.2%
Rural area	10	2.8%
Education level of respondent		

No schooling completed	10	2.8%
Kindergarten school to 8th grade	18	5.1%
Some high school, no diploma	68	19.3%
High school graduate/GED	143	40.5%
Some college, no degree	42	11.9%
Trade/technical/vocational training degree	32	9.1%
Associate degree	16	4.50%
Bachelor's degree	8	2.30%
Some graduate school, no degree	9	2.50%
Master's degree	2	0.60%
Professional degree	1	0.30%
Doctorate degree	4	1.10%
N	353	100.0%

The sample in this study was 100% African American males. Nearly 35% had never been married. The age range of the participants ranged from 18 years of age to 25 years of age with the majority being 23 years of age. Approximately, 22% were students. Eighty percent lived in cities. Forty percent reported having a high school diploma or GED (Table 2).

Table 3
Means and Standard Deviations, Study Variables

Variable	*N*	*M*	*SD*	Min	Max
Income of respondent	353	4.17	1.93	1	11
PCL-C scale	353	2.73	0.34	1	5
PFAV scale	353	2.51	0.36	1	4

The midpoint of the income scale was 6. The mean was under the midpoint with a score of 4.17 which suggested that the average respondent made between $30,000 and $40,000. The midpoint of the PCL-C scale was 3.0. The mean score of 2.73 was under the midpoint and indicated that the average respondent was slightly less than moderately

bothered by PTSD symptoms. The midpoint of the PFAV scale was 2.5. The mean score of 2.51 was at the midpoint which suggested that the average respondent was equidistant between a response of 'sometimes' and 'often' in regards to their feelings and past acts of violence (Table 2).

Cronbach Alpha

Table 4

Internal Consistency Values (Cronbach α)

Scale	α
PCL-C scale	0.263
PFAV scale	0.312

Tavakol and Dennick (2011) noted that the alpha statistic was developed by Lee Cronbach to provide a measure of the internal consistency of a scale as a function of its reliability. Measures of internal consistency (Cronbach α) are presented in Table 4.

Results for Research Question 3

Quantitative Research Question 3: What is the relationship between PTSD-like symptoms and past violent behavior among African American men?

H_0: There is no relationship between past violent behavior as measured by the Past Feelings and Acts of Violence (PFAV) and PTSD symptoms as evidence by scores on the Post Traumatic Checklist-Civilian (PCL-C).

H_A: There is a relationship between past violent behavior as measured by the Past Feelings and Acts of Violence (PFAV) and PTSD symptoms as evidence by scores on the Post Traumatic Checklist-Civilian (PCL-C).

Quantitative Research Question 3 was investigated via a Pearson correlation. As Ritchey (2008) noted that a Pearson correlation is the appropriate technique to determine if a statistical relationship exists between two continuous variables. Neuman (2011) noted that variables which are measured on a Likert scale can be considered as continuous data. In the current analysis scenario, past violent behavior was measured via the PFAV Likert scale instrument, while PTSD symptomology was measured via the PCL-C Likert scale instrument. Given these facts, a Pearson correlation becomes the appropriate statistical technique to investigate Quantitative Research Question 3 (Table 4). A correlation between the PCL-C and the PFAV was positive, moderate, and statistically significant at an alpha level of .001. Results suggest that as past violent actions increase, post-traumatic stress symptoms will also increase. On the basis of the data, there is support for the hypothesis that there is a relationship between past violent behavior as measured by the PFAV and PTSD symptoms as evidence by scores on the PCL-C. Statistical decision is to reject H0 and find support for HA for Quantitative Research Question 3.

Quantitative Research Question 3: Statistical Results

Table 5

Pearson Correlation Results, Quantitative Research Question 3

Measure	1		2
PCL-C scale	1.00		
PFAV scale	0.273	***	1.00

Note: *=p<.05, **=p<.01, ***=p<.001, two-tailed tests. N=353.

Results for Research Question 4

Quantitative Research Question 4: Is there a relationship between PTSD-like symptoms and past violent behavior among African American men when controlling for marital status, age, employment status, location where a respondent lives, educational level of respondent and income level of respondent?

H_0: There is no relationship between past violent behavior as measured by the PFAV and PTSD symptoms as evidence by scores on the PCL-C when controlling for marital status, age, employment status, location where a respondent lives, educational level of respondent and income level of respondent.

H_A: There is a relationship between past violent behavior as measured by the PFAV and PTSD symptoms as evidence by scores on the PCL-C when controlling for marital status, age, employment status, location where a respondent lives, educational level of respondent and income level of respondent.

In order to investigate the aspects of Quantitative Research Question 4, a multiple linear regression, also known as an OLS (for Ordinary Least Squares) regression was calculated. As Ritchey (2008) noted, an OLS regression is appropriate when the dependent variable of a research question (in this case, the PCL-C) is continuous in nature. Ritchey also noted that OLS regression is appropriate when there is more than one independent variable that serves as a predictor of a given dependent variable. In a regression equation, the independent variables can take the form of either continuous or categorical data. This condition is satisfied under the current circumstances (Table 6). The Omnibus F-Test was statistically significant ($F = 7.723$, $df = 7, 345$; $p < .001$). As

such, decomposition of effects within the regression model can proceed. The coefficient of determination, also known as the R^2 value, is .135. This value shows that 13.5% of the variation in the PCL-C scale can be explained by the seven independent variables in the equation. Among the seven independent variables, only the PFAV scale ($B = 0.267$, $p < .001$) and the location of a respondent ($B = -0.086$, $p < .001$) emerge as statistically significant predictors of PCL-C scale scores. The positive coefficient of the PFAV scale suggests that as past violence increases for a respondent, his or her PTSD symptoms also increase. The negative coefficient of location of respondent suggests that individuals who reside in cities are less likely to experience PTSD symptoms. Based on these results, there is support from the data for the hypothesis that there is a relationship between past violent behavior as measured by the PFAV and PTSD symptoms as evidence by scores on the PCL-C when controlling for marital status, age, employment status, location where a respondent lives, educational level of respondent and income level of respondent. Statistical decision is to reject H0 and find support for HA for Quantitative Research Question 4.

Quantitative Research Question 4: Statistical Results

Table 6

Multiple Linear Regression of PCL-C Scale on the Independent Predictors, Quantitative Research Question 4

Variable	*B*	*SE(B)*	*t*	*p*
Constant	2.284	0.254	8.995	0.000
PFAV scale	0.267	0.048	5.587	0.000
Marital status of respondent	-0.068	0.039	-1.759	0.079
Age of respondent	0.006	0.009	0.670	0.503
Employment status of respondent	0.057	0.042	1.358	0.175
Location of respondent	-0.086	0.024	-3.536	0.000
Education level of respondent	0.001	0.010	0.052	0.958
Income of respondent	-0.007	0.010	-0.682	0.496
N	353			
F	7.723			0.000
R^2	0.135			

The qualitative portion of this study involved interviewing African American male participants' about their experiences with violence following a phenomenological approach. Five African American males were selected to be interviewed and asked questions from the interview guide (Appendix C). One participant was excluded because he did not meet the inclusion criteria. A total of four participants were interviewed. The informed consent form was read to each participant and a copy given to each for their record. Verbal consent was obtained in order to begin the interview, otherwise the individual was thanked for his time and no further attempt was made to obtain consent. Once informed consent was obtained, interviews were audio-recorded. The duration of

the interviews ranged from 4 minutes 32 seconds to 9 minutes 20 seconds. The audio recording served as a means of accurately capturing the participants' responses. The researcher maintained a dialogue with the participants and asked follow-up questions to make sure participants' responses were interpreted correctly. Once the interviews were concluded, audio-recordings were transcribed.

Audio-recordings were uploaded using CyberLink software in order to listen to and transcribe the recordings. The basic software is free and allows for the uploading of audio files. This software was chosen in lieu of other qualitative analysis software because it was inexpensive and more sophisticated software was not needed to analyze the data from the sample size used in the qualitative portion of this study. Each of the audio recordings were transcribed into individual documents using basic word processing software. The individual transcribed verbatim responses were compiled and entered into a single word document. The seven open-ended questions functioned as headings and each participant's responses were listed beneath the corresponding question. Codes were assigned to commonly cited ideas. The frequency of commonly cited codes were determined and compared with results of the quantitative data.

Results for Research Question 1

Qualitative Research Question 1. What are the thoughts, actions and behaviors of young African American men who are exposed to violence?

Five major themes emerged from participants during interviews regarding the way they felt and behaved when exposed to violence. Participants were asked a series of

questions about their experiences as a witness or victim to violence followed by what they saw and how they felt. Results are presented below (Table 7).

Theme: Witnessing Violence

A common theme during the interviews was witnessing violence. All of those interviewed stated they had been a witness to some form of violence. The types of violence witnessed most often were shootings, stabbings and fights.

Theme: Weapon Carrying

Weapon carrying emerged as a behavior in this investigation with one respondent describing his experience witnessing a shooting by saying "I wasn't scared or nothing like that cause if anything…we'll have protection ourselves. Just to protect ourselves."

Theme: Avoidance

Another behavior associated with exposure to violence that was revealed was avoidance. Three of the respondents talked about avoiding conflict and learning "how to react." "I think it is important to teach other black America[ns] how to react to this type of stuff," stated a respondent. Staying away from environments known for violent situations was another strategy that was expressed. A respondent summed up this perspective, "Just stay away from that environment and try not to get into any arguments or anything like that."

In contrast another respondent, who had been involved in several fights, acknowledged that retaliating "probably wasn't a good idea," he still engaged in fighting stating "live and learn I guess."

Theme: Fear

When asked about feelings of fear, three respondents indicated that the threat of violence does not scare them. One respondent stated "it kinda makes me feel irritated. Some of those things that happen are just dumb and ignorant." However, another respondent stated he is often afraid so much so that he doesn't feel safe going outside. "I just feel afraid. The house is my best protection (referring to staying inside)."

Theme: Heightened Awareness (Hypervigilance)

While most of the respondents stated they had no feelings of fear due to the threat of violence, they all expressed heightened awareness of their surroundings. One respondent put it this way by saying, "not really paranoid, but more cognizant of what's going on around [me]."

Table 7

Themes Associated With the Thoughts, Actions and Behaviors of Young African American men Exposed to Violence

Themes	Comments
Witnessing Violence	'I [saw] somebody get shot at. They were ducking and hiding behind a car and they got hit in the leg and the hand.'
Weapon Carrying	'I wasn't scared or nothing like that cause if anything…we'll have protection ourselves. Just to protect ourselves.'
Avoidance	'I think it is important to teach other black America[ns] how to react to this type of stuff.' 'Just stay away from that environment and try not to get into any arguments or anything like that.'
Heightened Awareness (hypervigilance)	"…not really paranoid, but more cognizant of what's going on around [me]."
Fear	'It kinda makes me feel irritated. Some of those things that happen are just dumb and ignorant.' 'I just feel afraid. The house is my best protection (referring to staying inside).'

Results for Research Question 2

Qualitative Research Question 2. What are the influencing factors associated with recurrent violence among young African American males?

The influencing factors that were predominate during the interviews were weapon carrying, living in an urban neighborhood and heavy gang presence. Weapon carrying was a strategy that was used by one respondent to protect himself. Living in an urban neighborhood was associated with feeling unsafe and where a lot of violence occurs. “My neighborhood is basically where all the shooting goes on,” according to a respondent when describing his neighborhood. This was in contrast to the respondents who lived in suburban and rural neighborhoods who indicated their neighborhoods were safe. The presence of gangs was also indicated as a factor in recurrent violence. In response to violence in his neighborhood one respondent stated, “where I live at you can’t wear certain colors so if you wear the wrong color out the house you better run to the car or something.” The same respondent further went on to say, “it’s just gangs and they do what they do.”

Table 8

Triangulation of Quantitative and Qualitative Data

Measures	Quantitative	Qualitative
PFAV (Mean score of 2.51)	A mean of 2.51 on the PFAV scale suggested that the average respondent was equidistant between a response of 'sometimes' and 'often' for past feelings and acts of violence.	Participants who were interviewed were not asked about past acts of violence they may have engaged in but were asked if they had ever been a victim of violence or witnessed violence. One respondent did describe his experiences engaging in physical fights. Weapon carrying did emerge as a behavior associated with exposure to violence. One respondent put it this way, "…we'll have protection ourselves. Just to protect ourselves," when describing his experiences witnessing shootings.
PCL-C (mean score of 2.73)	The positive coefficient of the PFAV scale ($B = 0.267$, $p < .001$) suggests that as past violence increases for a respondent, his or her PTSD symptoms also increase. The negative coefficient of location of respondent ($B = -0.086$, $p < .001$) suggests that individuals who reside in cities are less likely to experience PTSD symptoms.	Participants who were interviewed were not assessed for PTSD symptoms, but responses did suggest characteristics associated with PTSD such as heightened awareness (hyperviligance), avoidance and fear were experienced by the respondents. Those who lived in suburban or rural areas felt less fear than those who lived in urban areas.

Summary

In this study, I found that as past violent actions increase, post-traumatic stress symptoms will also increase for the sample studied. Further, past acts of violence and location emerged as statistically significant predictors of PTSD. Results suggested that those participants who lived in cities were less likely to experience PTSD. This could be due to those living in rural areas are more isolated. It could be that there is less violence

in rural areas. Another possibility is that PTSD may be going under diagnosed in urban areas. Witnessing violence was a common theme during the interviews. Participants either resorted to weapon carrying or trying their best to avoid conflict in order to protect themselves. Heightened awareness was evident from all those interviewed. This could be indicative of hypervigilance and possibly a symptom of PTSD. Weapon carrying, living in an urban neighborhood and a heavy gang presence emerged as factors associated with recurrent violence among the participants. It is important to note that the results presented in this investigation are only relevant to the participants in the study and are not generalizable to the general population. However, the study results lay a foundation for further research. In Chapter 5, the implications of this research and recommendations for future study will be discussed.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to investigate the impact of PTSD on recurrent violence among African American males. The study was conducted using a convenience sample of African American males between the ages of 18-24 who self-reported experience with violence. Data analysis revealed that there was a positive correlation between past violent acts and PTSD. As acts of violence increase, so do PTSD symptoms. Past acts of violence and location were statistically significant predictors of PTSD. Qualitative interviews with a subset of participants confirmed the quantitative results.

Interpretations

This study was designed to examine the impact of PTSD on recurrent violence among African American males. Four research questions were addressed in this study. The conceptual framework for this study posited that exposure to violence and traumatic stress creates a cycle of recurrent violence (Figure 1). Kelly et al. (2010) indicated that those who experience interpersonal violence have the highest rates of chronic PTSD, and that being victims of violence increases vulnerability to PTSD. In this study, a positive correlation between past acts of violence and posttraumatic symptoms was observed among the study participants. The relationship suggested that as past violent acts increased, so did post-traumatic stress symptoms. This finding is consistent with the literature on PTSD and violence (Corbin et al., 2011; Donley et al., 2012; Freedy et al., 2010; Kelly et al., 2010; Richmond et al., 2011). Controlling for marital status, age,

employment status, location where a respondent lives, educational and income level of respondent, findings also showed a relationship between past acts of violence and post-traumatic stress symptoms. Findings also indicated that past feelings and acts of violence and location (i.e. where participants lived) were predictors of posttraumatic stress on the PCL-C. Eighty percent of the study participants indicated they lived in cities. However, a negative coefficient of location of respondent (B = -0.086, $p < .001$) suggested that those who lived in cities were less likely to experience PTSD symptoms. Scores on the PCL-C suggested that the average respondent was slightly less than moderately bothered by PTSD symptoms.

This finding is at odds with the work of Kelly et al. (2010), which suggests that the risk factors associated with PTSD were concentrated in urban areas. This discrepant finding could be due to under-diagnosis of PTSD in urban city centers. Another possibility could be recall bias on the part of participants. Study participants were recruited on the basis of their experience with some form of violence within the past 12 months to ensure their experiences were fresh enough to remember. That said, it is possible that participants' recollections may have faded over time, while other participants may not have wanted to relive their experience of post-traumatic stress due to stigma associated with PTSD.

The results gleaned from the qualitative interviews with a subset of participants suggested that there are risk factors and behaviors associated with violence exposure and recurrent violence. Factors such as avoidance and heightened awareness suggested possible PTSD symptoms that was consistent with the research literature (Corbin et al.,

2011, 2013; Donley et al., 2012; Mokrue et al., 2011; Roberts, et al., 2011; Watkins, et al., 2010) and provided support for the conceptual framework put forth in this study.

Limitations of the Study

There were several limitations associated with this study. The first limitation is the sample size. While the sample size was sufficient to produce statistically significant results, both scales used in the survey tool yielded low reliability scores, even though the research literature supported high internal consistency scores of reliability for both the PCL-C (Mokrue et al., 2011; Ruggiero et al., 2003) and PFAV (Plutchik & van Praag, 1990; Suris, 2004). Low reliability scores could be attributed to the use of a convenience sample. It is also possible that participants may not have followed the directions and did not answer the questions honestly, even though the survey was anonymous. Further study is warranted using a random sample of participants so as to better increase the generalizability of results.

The second limitation stems from the semi-structured interviews that were conducted with a subset of participants in order to answer the research questions regarding the violent experiences encountered by young African American men. Avoidance and heightened awareness were behaviors that were common among the respondents and indicative of PTSD symptoms but were not assessed at the time of the interviews. Future researchers should consider including screening participants for PTSD symptoms using the PCL-C.

Participant recruitment was another limitation of this study. Participants were recruited using social media and an assistant who recruited participants. Due to the

anonymous nature of the study, none of the participants who completed the survey were seen. It was assumed that those who consented to participate self-reported that they met the criteria for inclusion in the study and were answering the questions honestly. To facilitate participant recruitment, an assistant was hired. The assistant was supplied with a copy of the informed consent and participant recruitment flyer which provided details about the nature of the study along with the hyperlink to the online survey. The assistant identified potential study participants, thereby ensuring potential respondents met the inclusion criteria. Once this was confirmed, the assistant directed respondents to the survey link to complete the survey and then confirmed that the survey was completed. While constant communication was maintained, it was difficult to ensure that the assistant understood the study parameters and was recruiting suitable participants. This could have attributed to the lower than expected reliability scores. While the participants that were interviewed seemed willing to share their stories, the lack of an incentive may have hindered recruitment.

Recommendations

Further study of the PCL-C and PFAV as reliable tools is warranted. Even though the reliability score for the PCL-C was low in this study, the research literature suggests the PCL-C is a reliable tool for assessing PTSD symptoms (Lang & Stein, 2005). Further research should test the use of the PCL-C during emergency department visits of African American male patients presenting for treatment of injuries sustained through violence. Interviews with African American males revealed that witnessing violence was a common occurrence for them, and as a consequence, engaged in

behaviors like avoidance and developed a heightened awareness of their surroundings. Behavior of this type is indicative of PTSD symptoms. More research with a larger sample size is needed to determine the prevalence of PTSD among young African American males who are exposed to violence. Screening for PTSD may facilitate early detection and interventions to reduce the incidence of recurrent violence.

Social Change Implications

There is an opportunity to improve the lives of African American males and reduce morbidity and mortality due to violence. I confirmed two things: first, African American males are exposed to a significant amount of violence; second, they may exhibit signs of PTSD symptoms as a consequence of their exposure. One of the aims of this research was to investigate the extent that African American males are exposed to violence in the hopes that further research would reveal strategies that can reduce violence exposure for this population. I did not address social and environmental risks of resource-poor communities; but, strategies aimed at long-range systems changes in policies, community investment and community engagement may help to reduce the risk factors associated with violence. Reductions in violence would reduce PTSD symptoms experienced by this population. The results of this study suggest that violence exposure cause PTSD symptoms. The results of this study also suggest that there is a need for outreach to assess and screen African American males who live in areas that have high violence rates for PTSD symptoms. Screening individuals who have been exposed to violence or sustained an injury due to violence for PTSD may prevent future violence and further behavioral health pathology through early diagnosis and treatment.

Conclusions

In this study, I found that as past acts of violence increase, so do PTSD symptoms. Interviews with a subset of participants revealed that factors like weapon carrying, residing in cities, and gangs were associated with recurrent violence. Witnessing violence was a common theme among those interviewed. Behaviors like avoidance and heightened awareness of their surroundings was indicative of possible PTSD-like symptoms among the respondents. The results of this study lend support for the hypotheses and conceptual framework put forth in Chapter 1. The results of this investigation lead back to the burning question this study was attempting to answer. Does past exposure to violence cause African American males to be at a greater risk of developing PTSD symptomology and does the development of PTSD symptomology in African American males lead to a greater propensity to commit future acts of violence? The results suggested that exposure to violence does indeed increase the risk for PTSD symptoms. Posttraumatic stress symptoms can lead to behaviors like avoidance and heightened awareness (i.e. hypervigilance) that can result in behaviors like weapon-carrying, which increase the likelihood of future violence. Early identification and treatment for PTSD among African American males who have been exposed to violence may reduce the incidence of future violence and injury. More research is needed to determine if screening and treatment for PTSD can reduce risks to recurrent violence and injury.

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Appendix A: Post-Traumatic Checklist-Civilian

PTSD Check List – Civilian Version (PCL-C)

The PCL is a standardized self-report rating scale for PTSD comprising 17 items that correspond to the key symptoms of PTSD. Two versions of the PCL exist: 1) PCL-M is specific to PTSD caused by military experiences and 2) PCL-C is applied generally to any traumatic event.

The PCL can be easily modified to fit specific time frames or events. For example, instead of asking about "the past month," questions may ask about "the past week" or be modified to focus on events specific to a deployment.

How is the PCL completed?
 The PCL is self-administered
 Respondents indicate how much they have been bothered by a symptom over the past month using a 5-point (1–5) scale, circling their responses. Responses range from **1** Not at All – **5** Extremely

How is the PCL Scored?
12) Add up all items for a total severity score
or
2) Treat response categories **3–5** (Moderately or above) as symptomatic and responses **1–2** (below Moderately) as non-symptomatic, then use the following DSM criteria for a diagnosis:
- Symptomatic response to at least 1 "B" item (Questions 1–5),
- Symptomatic response to at least 3 "C" items (Questions 6–12), and
- Symptomatic response to at least 2 "D" items (Questions 13–17)

Are Results Valid and Reliable?
 Two studies of both Vietnam and Persian Gulf theater veterans show that the PCL is both valid and reliable (Additional references are available from the DHCC)

What Additional Follow-up is Available?
 All military health system beneficiaries with health concerns they believe are deployment-related are encouraged to seek medical care
 Patients should be asked, **"Is your health concern today related to a deployment?"** during all primary care visits.
• If the patient replies **"yes,"** the provider should follow the Post-Deployment Health Clinical Practice
Guideline (PDH-CPG) and supporting guidelines available through the DHCC and www.PDHealth.mil

DHCC Clinicians Helpline: 1 (866) 559-1627 DSN: 662-6563 www.PDHealth.mil

PDH-CPG Tool Kit Pocket Cards Version 1.0 December 2003

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

Appenidix B: Past Feelings and Acts of Violence

BMDS Behavioral Measurement Database Services

Health and Psychosocial Instruments (HaPI)

Date: August 11, 2011

To: Adrian Cox

From: Evelyn Perloff, PhD

Enclosed is the:

Past Feelings and Acts of Violence Scale
Robert Plutchik

As I have indicated authors like to receive feedback on your study. All that is asked is that you provide a brief summary of your findings upon completion of your study/project. In addition, we encourage you to send a full report which we will consider for inclusion in Health and Psychosocial Instruments (HaPI) and which you may list on your vita/resume.

You have the author's permission to use the above instrument.

Please note that the instruments are for a single study only. It is, of course, necessary to provide the appropriate title and author credit in reproduced material and in your report.

PO Box 110287 Pittsburgh, PA 15232-0787
Phone: 412-687-6850 Fax: 412-687-5213 E-mail: bmdshapi@aol.com

Past Feelings and Acts of Violence Scale
Robert Plutchik

Acronym

PFAV

Primary Source

Plutchik, R., & van Praag, H. M. (1990). A self-report measure of violence risk: II. Comprehensive Psychiatry, 31, 450-456.

Purpose Statement

Past Feelings and Acts of Violence Scale (PFAV) is designed to measure respondents' risk of violence. Items focus on feelings of anger and acts of violence against others. Respondents are asked whether they have beaten strangers or members of their family, whether they lose their temper easily, whether they carry and use weapons, whether they have been arrested, and so forth.

Response Options

The PFAV is a self-report questionnaire and contains 4-point Likert-type scales ranging from "never" to "very often" and "never" to "more than twice".

Sample Items

"Do you find that you get angry for no reason at all?"; "Have you ever hit or attacked someone who is not a member of your family?"; and "Are weapons easily accessible to you?"

Reliability

Coefficient alpha reliability = .77 (N = 100).

Number of Questions

12.

Directions for Scoring

To obtain total scores for items 1-11, sum responses ranging from “never” to “very often”/”more than twice” and weighted from 0 to 3. Item 12 calls for frequencies and/or percentages.

17959

Health and Psychosocial Instruments
(HaPI)

Past Feelings and Acts of Violence Scale

Robert Plutchik

Past Feelings and Acts of Violence Scale

Robert Plutchik

Name _____ Age _____ Sex _____

Instructions

Please read each statement and indicate how often you do or feel each of the things described, by placing an "X" in the appropriate space.

	Never	Some-times	Often	Very Often
1. Do you find that you get angry very easily?	____	____	____	____
2. How often do you feel very angry at people?	____	____	____	____
3. Do you find that you get angry for no reason at all?	____	____	____	____
4. When angry, do you get a weapon?	____	____	____	____
5. Have you ever caused injury in a fight (for example: bruises bleeding, or broken bones)?	____	____	____	____
6. Have you ever hit or attacked a member of your family?	____	____	____	____
7. Have you ever hit or attacked someone who is not a member of your family?	____	____	____	____
8. Have you ever used a weapon to try to harm someone?	____	____	____	____
9. Are weapons easily accessible to you?	____	____	____	____
	Never	Once	Twice	More Than Twice
10. How often have you been arrested for a non-violent crime such as shoplifting or forgery?	____	____	____	____
11. Have you ever been arrested for a violent crime such as armed robbery or assault?	____	____	____	____

	No	Yes
12. Do you keep weapons in your home that you know how to use?	____	____

Appendix C: Interview Questions

Experiences Witnessing Violence

- What are your experiences as a witness to violence? What did you see? How did it make you feel? What did you do?
    - For example, seeing someone (note: read examples to each participant being interviewed):
        - Being physically attacked by someone
        - Being sexually assaulted
        - Being threatened
        - Being chased
        - Being robbed by force
        - Being forced or threatened to do something they didn't want to do
        - Being seriously hurt by a violent attack
        - Being shot or shot at with a gun
        - being killed
        - seeing a dead body in the community (besides at funerals, wakes, burials) or,
        - hearing gunshots

Victimization

- Describe your experiences as a victim of violence. What happened? How did you feel?
    - For example, have you been:
        - Chased by people
        - threatened with serious physical harm
        - seriously hurt during a violent attack
        - physically attacked
        - shot at (not hit)
        - Tried to (or did) kidnap you
        - Forced or threatened with violence by someone to get you to do something you didn't want to do
        - Robbed after someone used violence on you or,
        - has someone tried or forced their way into your home
- Have you ever been treated in a hospital emergency room for injuries due to a fight, stabbing, or shooting? If yes, what for? What did the doctors and nurses tell you?

- Tell me a little about where you live-what is it like living in your neighborhood?

- Does the threat of violence make you afraid? How do you handle the fear of violence?
- How do you protect yourself?

- Is there anything that has not been discussed that you feel is important to this study you would like to share at this time?

PsycTESTS

Community Experiences Questionnaire

PsycTESTS Citation:
Schwartz, D., & Proctor, L. J. (2000). Community Experiences Questionnaire [Database record]. Retrieved from PsycTESTS. doi: 10.1037/t10045-000

Test Shown: Full

Test Format:
Items are rated on a 4-point rating scale (1 = never, 2 = once, 3 = a few times, 4 = lots of times).

Source:
Schwartz, David, & Proctor, Laura J. (2000). Community violence exposure and children's social adjustment in the school peer group: The mediating roles of emotion regulation and social cognition. Journal of Consulting and Clinical Psychology, Vol 68(4), 670-683. doi: 10.1037/0022-006X.68.4.670

PsycTESTS®

doi: 10.1037/t10045-000

Community Experiences Questionnaire
CEQ

Items

Exposure through victimization

How many times has somebody broken in or tried to force their way into your home?
How many times has somebody threatened to hurt you really badly?
How many times have you been chased by gangs, other kids, or adults?
How many times has somebody hit, punched, or slapped you?
How many times has somebody stolen something from you using violence (like somebody "mugging" you or stealing something from you after beating you up or threatening to hurt you)?
How many times has somebody fired a gun at you or at your home?
How many times has somebody tried to hurt you with a knife or other sharp object?
How many times has somebody tried to hurt you by hitting you with a stick, bat, pole, or club?
How many times has somebody thrown a bottle, rock, or other hard object at you?
How many times has somebody tried to use violence or threats to get you to do something that you didn't want to do?
How many times have you been arrested or taken away by the police?

Exposure through witnessing

How many times have you seen or heard somebody else get threatened?
How many times have you seen somebody else get chased by gangs, other kids, or adults?
How many times have you seen somebody trying to break in or force their way into somebody else's home?
How many times have you seen somebody else get hit, punched, or slapped?
How many times have you seen somebody get robbed or have something stolen from them by force (like a person beating somebody up and then taking their money)?
How many times have you seen somebody carrying a gun or other weapon (besides police, military, and security guards)?
How many times have you seen or heard gunshots?
How many times have you seen somebody try to hurt another person with a knife or other sharp object?
How many times have you seen somebody get hit with a stick, bat, pole, or club?
How many times have you seen somebody have a bottle, rock, or other hard object thrown at them?
How many times have you seen somebody get arrested or taken away by the police?
How many times have you seen a dead body (besides at funerals, wakes, or burials)?
How many times have you seen or heard somebody trying to use force or threats to get another person to do something they didn't want to do?
How many times have you seen somebody get killed?

Note . For both subscales, children were asked to rank the frequency with which they had experienced each item on a 4-point rating scale (1 = *never,* 2 = *once,* 3 = *a few times,* 4 = *lots of times)*

PsycTESTS

Community Violence Exposure Survey

PsycTESTS Citation:
Saltzman, W. R., Layne, C. M., & Steinberg, A. M. (1998). Community Violence Exposure Survey [Database record]. Retrieved from PsycTESTS. doi: 10.1037/t17816-000

Test Shown: Full

Test Format:
The instrument is scored by identifying endorsements of one or more forms of trauma exposure.

Source:
Saltzman, William R., Pynoos, Robert S., Layne, Christopher M., Steinberg, Alan M., & Aisenberg, Eugene. (2001). Trauma- and grief-focused intervention for adolescents exposed to community violence: Results of a school-based screening and group treatment protocol. Group Dynamics: Theory, Research, and Practice, Vol 5(4), 291-303. doi: 10.1037/1089-2699.5.4.291

PsycTESTS

doi: 10.1037/t17816-000

Community Violence Exposure Survey
CVES

Items

Direct victimization
Badly hurt in violent incident (needed to see a doctor)
Stabbed or attacked with knife or sharp object
Shot at with a gun
Shot with a gun
Choked, strangled, or smothered (not playing)
Tried to (or did) kidnap me
Been badly hurt in an accident (needed to see a doctor)

Witnessing
Seen someone badly hurt or killed in a violent incident
Seen someone stabbed or attacked with a knife or sharp object
Seen someone shot or shot at with a gun
Seen someone choked, strangled, or smothered (not playing)
Seen someone kill someone else (on purpose)
Seen someone attempt or commit suicide

Family member or close friend victimized
Family member was badly hurt in an accident
Family member was badly hurt in violent accident
Close friend was badly hurt in an accident or violent incident
Family member was killed in an accident
Family member was killed in a violent incident
Close friend was killed in an accident or violent incident
Family member or friend committed suicide

Threatened
Been threatened with serious physical harm
Been threatened with a weapon

Natural disasters and wars
Lived in a war where there was fighting, people hurt, or dead bodies
Been in a big earthquake that badly damaged the building I was in
Been in another kind of disaster like a fire, hurricane, or flood

PsycTESTS

Exposure to Violence and Criminal Behavior on the Streets Questionnaire

Note: Test name created by PsycTESTS

PsycTESTS Citation:
Kipke, M. D., Simon, T. R., Montgomery, S. B., Unger, J. B., & Iversen, E. F. (1997). Exposure to Violence and Criminal Behavior on the Streets Questionnaire [Database record]. Retrieved from PsycTESTS. doi: 10.1037/t09996-000

Test Shown: Full

Test Format:
Questions concerning witnessing, victimization, and perpetration have the response options of (a) ever during the participant's lifetime and (b) since the participant became homeless or began working on the streets. The fear of violence items have three response choices: not at all afraid, somewhat afraid, and very afraid.

Source:
Kipke, Michele D., Simon, Thomas R., Montgomery, Susanne B., Unger, Jennifer B., & Iversen, Ellen F. (1997). Homeless youth and their exposure to and involvement in violence while living on the streets. Journal of Adolescent Health, Vol 20(5), 360-367. doi: 10.1016/S1054-139X(97)00037-2. © 1997 by Elsevier. Reproduced by Permission of Elsevier.

PsycTESTS®

doi: 10.1037/t09996-000

Exposure to Violence and Criminal Behavior on the Streets Questionnaire

Items

Witnessing violence

Seen someone being physically attacked by another person
Seen someone being sexually assaulted
Seen someone who was seriously hurt after violent event or attack
Seen someone being killed by another person
Seen a dead person somewhere in community

Victimization

Been sexually assaulted, molested, or raped
Been chased by people
Been threatened with serious physical harm by someone
Been seriously hurt after violent attack
Been slapped, punched, hit, burned, or beaten up by someone
Been attacked or stabbed with a knife
Been shot at (not hit)
Been shot and hit by gunfire

Perpetration of violence

Attacked or stabbed someone with knife
Shot at someone

Fear of violence

Afraid of being shot
Afraid of being stabbed with knife
Afraid of being beaten up
Afraid of being sexually assaulted, molested, or raped

Appendix D: Demographic Questions

Age
What is your age?_____
Prefer not to answer____

Sex
What is your sex?
Male____
Female____
Prefer not to answer____

Race/Ethnicity
How do you describe yourself? Check the one option that best describes you
American Indian or Alaska Native____
Hawaiian or Other Pacific Islander____
Asian or Asian American____
Black or African American____
Hispanic or Latino____
Non-Hispanic White____
Prefer not to answer____

Marital status
Married____
Divorced____
Widowed____
Separated____
Never been married____
A member of an unmarried couple____
Prefer not to answer____

Employment status
Are you currently:
Employed for wages____
Self-employed____
Out of work for more than 1 year____
Out of work for less than 1 year____
A homemaker____
A student____
Retired____
Unable to work____
Prefer not to answer____

Education status

What is the highest level of school you have completed?

No schooling completed____
Nursery school to 8th grade____
Some high school, no diploma____
High school graduate, diploma or the equivalent (for example: GED)____
Some college credit, no degree____
Trade/technical/vocational training____
Associate degree____
Bachelor's degree____
Master's degree____
Professional degree (MD, DDS, JD)____
Doctorate degree (ph.d)____
Prefer not to answer____

Income

What is your total household income?

•Less than $10,000____
•$10,000 to $19,999____
•$20,000 to $29,999____
•$30,000 to $39,999____
•$40,000 to $49,999____
•$50,000 to $59,999____
•$60,000 to $69,999____
•$70,000 to $79,999____
•$80,000 to $89,999____
•$90,000 to $99,999____
•$100,000 or more____

Area you live in

Urban___
Suburban___
Rural____

Appendix E: Questionnaire

Instructions: Please answer the questions below using a pen or pencil. Mark your answers by using an X or ✓ or by filling in the answer on the blank line or in the box. Please give the best answer you can.
To start, please answer a few demographic questions. Please answer all the questions below honestly. Remember that all of your answers will be kept strictly confidential.

1. Are you ____male ____female

Age

2. What is your age? _____

Race/Ethnicity

3. How do you describe yourself? Check the one option that best describes you
American Indian or Alaska Native____
Hawaiian or Other Pacific Islander____
Asian or Asian American____
Black or African American____
Hispanic or Latino____
Non-Hispanic White____
Other [Write in blank] _____

Marital status

4. Which of the following describes your status? Please select only one.
Married____
Divorced____
Widowed____
Separated____
Never been married____
A member of an unmarried couple____
Other [write in blank] _____

Employment status

5. What is your current employment status? Please select only one.
Employed for wages____
Self-employed____
Out of work for more than 1 year____
Out of work for less than 1 year____
A homemaker____
A student____
Retired____
Unable to work____

Instructions: Please answer the questions below using a pen or pencil. Mark your answers by using an X or ✓ or by filling in the answer on the blank line or in the box. Please give the best answer you can.

Education status

6. What is the highest level of school you have completed?

No schooling completed____
Nursery school to 8th grade____
Some high school, no diploma____
High school graduate, diploma or the equivalent (for example: GED) ____
Some college credit, no degree____
Trade/technical/vocational training____
Associate degree____
Bachelor's degree____
Master's degree____
Professional degree (MD, DDS, JD) ____
Doctorate degree (Ph.D.) ____

Income

7. What is your total household income?

•Less than $10,000____
•$10,000 to $19,999____
•$20,000 to $29,999____
•$30,000 to $39,999____
•$40,000 to $49,999____
•$50,000 to $59,999____
•$60,000 to $69,999____
•$70,000 to $79,999____
•$80,000 to $89,999____
•$90,000 to $99,999____
•$100,000 or more____

Area you live in

8. Which of the following best describes where you live right now? Please select only one.

City___
Suburb___
Rural____
Small town_____
Other [write in blank]_____

The next set of questions are taken from the PTSD Checklist-Civilian version rated on a scale of 1 to 5, with 1 being "not at all" bothered and 5 being "extremely" bothered. Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem in the past year.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite of bit (4)	Extremely (5)
1.	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?					
2.	Repeated, disturbing dreams of a stressful experience from the past?					
3.	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?					
4.	Feeling very upset when something reminded you of a stressful experience from the past?					
5.	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience					

	from the past?					
No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite of bit (4)	Extremely (5)
6.	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?					
7.	Avoid activities or situations because they remind you of a stressful experience from the past?					
8.	Trouble remembering important parts of a stressful experience from the past?					
9.	Loss of interest in things that you used to enjoy?					
10.	Feeling distant or cut off from other people?					
11.	Feeling emotionally numb or being unable to have loving feelings for those close to you?					

12.	Feeling as if your future will somehow be cut short?					
13.	Trouble falling or staying asleep?					
14.	Feeling irritable or having angry outbursts?					
No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite of bit (4)	Extremely (5)
15.	Having difficulty concentrating?					
16.	Being “super alert” or watchful on guard?					
17.	Feeling jumpy or easily startled?					

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You are almost done. The following questions are from the Past Feelings and Acts of Violence Questionnaire. Please be honest when you answer them. Remember, your name and identifying information will be removed and replaced with a unique code. You will not get into any trouble by answering these questions. Please read each statement and indicate how often you do or feel each of the things described in the past 12 months, by placing an "X" in the appropriate space.

	Never	Sometimes	Often	Very Often
1. Do you find that you get angry very easily?				
2. How often do you feel very angry at people?				
3. Do you find that you get angry for no reason at all?				
4. When angry, do you get a weapon?				
5. Have you ever caused injury in a fight (for example bruises, bleeding, or broken bones)?				
6. Have you ever hit or attacked a member of your				

family?				
	Never	Once	Twice	More than twice
7. Have you ever hit or attacked someone who is not a member of your family?				
8. Have you ever used a weapon to try to harm someone?				
9. Are weapons easily accessible to you?				
10. How often have you been arrested for a non-violent crime such as shoplifting or forgery?				
11. Have you ever been arrested for a violent crime such as armed robbery or assault?				

12. Do you keep weapons in your home that you know how to use? Yes No