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MALE SURVIVORS OF URBAN VIOLENCE AND TRAUMA

A qualitative analysis of jail detainees

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2015

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This evaluation was supported by Grant #s 2010-DJ-BX-0015 and 2009-DJ-BX-0023 awarded to the Illinois Criminal Justice Information Authority by the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions contained within this document are those of the authors and do not necessarily represent the official position or policies of the Illinois Criminal Justice Information Authority or the U.S. Department of Justice.

Suggested citation: Reichert, J., Ruzich, D., & Osher, M. (2015). *Male survivors of urban violence and trauma: A qualitative analysis of jail detainees*. Chicago, IL: Illinois Criminal Justice Information Authority.

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Acknowledgements

The Authority wishes to thank the following individuals and agencies for providing assistance and guidance for this project:

Tom Dart, *Cook County Sheriff*
Arthur Lurigio, Ph.D., *Loyola University Chicago*

The agency would like to acknowledge the following Authority staff and former staff for their assistance:

Megan Alderden
John Maki
Cristin Monti Evans
Mark Myrent

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Key findings

Urban violence is a major public health concern and at epidemic levels in some neighborhoods, directly impacting the mental health of its residents (Morris, n.d.). The rate of posttraumatic stress disorder (PTSD) among urban populations is estimated to be around 31 percent, higher than the PTSD rate among returning Iraq war veterans of 17 percent (Donley et al., 2012; Hoge, Terhakopian, Castro, Messer, Engel, 2007). Research has found traumatic events in urban neighborhoods can be associated with later criminal activity and substance use (Breslau, Chilcoat, Kessler, & Davis, 1999; Breslau, Davis, & Andreski, 1995; Scott, 2010; Widom & Maxfield, 2001). An estimated 6.3 million people in the United States are in need of PTSD treatment, with higher proportions of sufferers concentrated in urban cities (Norris & Slone, 2013).The cost of gun violence is estimated at $174 billion including loss of work productivity, medical care, pain and suffering, insurance, and criminal justice expenses (Miller, 2012).

Researchers from the Illinois Criminal Justice Information Authority (Authority) and WestCare Foundation Illinois documented self-reported characteristics, experiences, and backgrounds of male survivors of urban violence. Researchers conducted in-depth interviews with six men receiving substance abuse treatment while in custody at Cook County jail. All showed symptoms of mental health issues, trauma histories, and/or PTSD. The interviews focused on the men's life stories, traumas they experienced, and their coping mechanisms. Some may assume these men were street savvy, immune to the continuous violence around them and to blame for their circumstances, but the research revealed the men were profoundly negatively affected by their experiences in their homes and neighborhoods.

All men said their neighborhoods were dangerous growing up and that crime and gunfire were common. All had been shot at and physically assaulted. Most had been robbed at gunpoint and stabbed. Most had witnessed someone's murder or someone being seriously injured. Three experienced the sudden loss of a family member who was murdered; all thought at least once they would be killed or seriously injured.

Trauma occurred early. By the age of five, half of those interviewed had already experienced a traumatic event. Domestic disruption and violence was common—three saw their fathers physically abuse their mothers as children and all were either separated from, or abandoned by, a parent. Half of the interviewees were sexually abused or experienced unwanted sexual contact. Half had periods of homelessness. Two interviewees had been diagnosed with a mental illness, one had attempted suicide, and one had serious physical health issues.

Their reactions to traumatic experiences varied. All said they used alcohol or drugs as a way to cope. Five began using drugs and/or alcohol during early adolescence. Four reported nightmares and decreased intimacy or trust in others. Three suffered physical responses to stressful events, including anxiety, cold sweats, and difficulty concentrating. Two noticed impaired relationships with family or friends.

Implications for policy and practice

Further understanding and treatment are necessary to help individuals heal from trauma and improve public health and criminal justice outcomes. Several implications for policy and practice were identified during the course of this research.

Offer treatment to male trauma survivors

None of the interviewees received professional help or employed positive coping skills to address the trauma they had experienced. Screening for trauma and PTSD is needed to uncover issues and develop a treatment plan. Service providers and criminal justice personnel can use a trauma-informed approach—understanding trauma signs and symptoms to support treatment protocols and limit re-traumatization (SAMHSA, 2015). Training for screening of trauma, as well as trauma-based treatment is necessary (Adams, 2010). Best practices for trauma/PTSD treatment include individual or group cognitive behavioral therapy and the treatment of co-occurring disorders when substance abuse is present (Beck & Coffey, 2005).

Increase awareness of male survivors of urban trauma

Trauma can affect anyone, but the men growing up in urban neighborhoods are more at-risk for experiencing trauma and developing PTSD than those non-urban areas (Reese, et al., 2012). Public awareness of the trauma experienced by urban males, particularly among service providers and criminal justice system practitioners, is needed. Urban men who seek medical treatment after a traumatic event are rarely referred to mental health services (Rich & Grey, 2005).

Conduct further research on urban trauma

Research is needed to better understand the prevalence of trauma among different populations and those most at-risk, and identify strategies to help victims of urban violence (Rich & Grey, 2005). Better awareness and understanding of the prevalence of PTSD in urban areas will support development of best practices to identify and treat individuals (Ouimette, Read, Wade, & Tirone, 2010).

Introduction

Urban violence is a major public health concern; in some American urban neighborhoods violence is at “epidemic levels” (Morris, n.d., p.3). Urban areas have higher crime rates and suffer from a proliferation of gangs, guns and drugs (McCart, 2007). The prevalence of violence in urban communities has a direct impact on the mental health of its residents (Morris, n.d.).

PTSD can occur following traumatic events such as physical or sexual assault, childhood abuse, war, natural or manmade disaster, act of terrorism, fire, sudden death of a loved one, chronic or terminal illness of a child, and plane or motor vehicle crash (Norris & Slone, 2007; Breslau, Davis, & Andreski, 1995). Research estimates the rate of PTSD among urban populations at 24 to 31 percent (Breslau, Davis, Andreski, & Peterson, 1991; Donley, Habib, Jovanovic, Kamkwalala, Evces, Egan, Bradley, & Ressler, 2012). Rates of PTSD found in poor, high-risk populations in urban neighborhoods are as high or higher as PTSD noted in returning Iraq war veterans (17 percent) (Donley, Habib, Jovanovic, Kamkwalala, Evces, Egan, Bradley, & Ressler, 2012).

Little research is available on urban male victims of violence, trauma, and PTSD (Rich & Grey, 2005) and even less research is available on those in criminal justice populations. Research has shown the rate of PTSD is higher for criminal justice populations than for the general population and a link exists between traumatic events and later criminal activity (Widom & Maxfield, 2001; Scott, 2010). Research in an urban city found a strong association between trauma exposure/PTSD and increased risk of involvement in the criminal justice system (Donley et al., 2012). In addition, research has shown a relationship between trauma, subsequent PTSD, and substance use (Breslau, Chilcoat, Kessler, & Davis, 1999; Breslau, Davis, & Andreski, 1995). This study examined the nature and extent of trauma among men held in custody in a large urban jail. Researchers interviewed six men who first completed surveys which indicated they had some mental health-related issues, trauma, and/or PTSD. The qualitative interviews allowed researchers to examine the particularity and complexity of their experiences. These case studies shed light on the circumstances of, and types of, mental health issues and trauma experienced, providing a richer picture of mental health among male jail detainees.

Literature review

Each day, an average of 32 Americans die from gun violence and a disproportionate percentage of them are Black men in urban neighborhoods (Follman, Lurie, Lee, & West, 2015). Major U.S. cities have higher firearm homicides (Serafin, 2010). According to the Centers for Disease Control and Prevention, U.S. firearms caused 11,000 homicide deaths, or 3.5 per 100,000 people. Researchers estimated the total cost of gun violence at $174 billion including work lost, medical care, pain and suffering, criminal-justice expenses, and insurance (Miller, 2012). Howell & Abraham (2013) found hospital costs for firearm assault injuries were nearly $630 million.

Urban violence is complex and due in part to inequality within communities' social capital, long histories of power struggles, and inadequate infrastructure (Dreier, 1996). For Chicago residents, and residents of other major U.S. cities, gun violence varies drastically for those living a few streets apart (Demby, 2014). Homicide rates in Chicago neighborhoods less than 10 miles apart vary. Jefferson Park on Chicago's Northwest side, for instance, has a homicide rate of 3.1 per 100,000 residents while West Garfield Park on the city's West side has a rate of 64 per 100,000 people (Papachristos, 2009).

Gangs contribute to urban violence and an estimated 10 percent of youth in low income neighborhoods end up joining gangs (Vigil, 2003). In recent years, gang prevalence has increased with greater concentration in urban areas (National Gang Center, n.d.). Estimates indicate there are 30,000 U.S. gangs and 850,000 gang members (National Gang Center, n.d.).

Gangs are usually small groups of male youth who grow up together in similar cohorts (Vigil, 2003). Gangs adopt values to obtain economic prosperity, use violence to control geographical areas for drug commerce, and obtain strength through firearms (Police Executive Research Forum, 1998). Gang members must prove their loyalty and gain respect in order to create personal and group identity, as well as protect themselves (Anderson, 1999). About 51 percent of imprisoned youth recorded daily weapon carrying within the last 12 months (Vaughn, Howard, Harper-Chang, 2006).

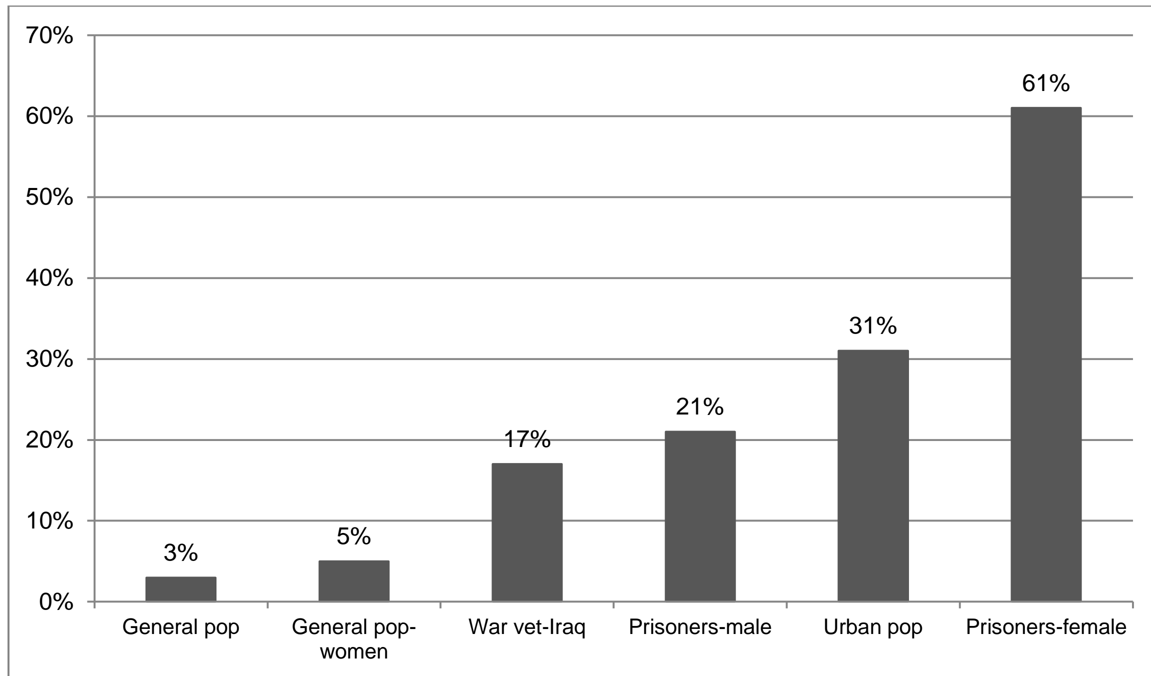
Research has shown that exposure to violence and trauma, such as witnessing or experiencing personal assaults or life-threatening events can have a significant impact on an individual's level of functioning, interpersonal relationships, and physical and mental health (Zatzick et al., 1997; Segman, Shalev, & Gelernter, 2007; Price & Stevens, 2009). Childhood traumas may lead to emotional and psychological effects on children such as sleep disorders, regression, and feelings of self-blame and helplessness (Goodwin, 1998).

Exposure to traumatic events may cause some to develop PTSD, an anxiety disorder found in the *Diagnostics and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*). Symptoms often appear within three months after a traumatic event, but may be delayed months or even years (American Psychiatric Association, 2000).).

*Figure 1*depicts different populations that were PTSD-symptomatic (current not lifetime)—urban populations have PTSD rates of 31 percent, higher than Iraq war veterans and male prisoners. Of

a sample of patients at urban trauma center in Chicago, 42 percent screened positive for PTSD (Reese, et al., 2012).

Figure 1
PTSD-symptomatic by population



Data sources (from left to right): Kessler, Sonnega, Bromet, Huges, & Nelson, 1995; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993; Hoge, Terhakopian, Castro, Messer, & Engel, 2007; Gibson, Holt, Fondacaro, Tang, Powell, & Turbitt, 1999; Donley, Habib, Jovanovic, Kamkwalala, Evces, Egan, Bradley, & Ressler, 2012; Reichert & Bostwick, 2010.

Research has shown those with PTSD have lower levels of everyday functioning and diminished well-being (Zatzick, et al., 1997). Individuals with PTSD have difficulty forming and maintaining relationships and are five times as likely to be unemployed (Zatzick, et al., 1997; Jordan et al., 1992). In families where a spouse is suffering from PTSD, there are higher rates of divorce, family violence, emotional abuse, and marital discord (Jordan et al., 1992; Byrne & Riggs, 1996; Price & Stevens, 2009; Carlson & Ruzek, 2007; Nelson & Slone, 2007). Individuals diagnosed with PTSD have more difficulty with self-expression and communication which leads to conflict within close relationships (Carroll, Rueger, Foy, & Donahoe, 1985). Furthermore, spouses of individuals suffering from PTSD are often forced to take on more childcare and household responsibilities while coping with their partners' PTSD symptoms (Nelson & Wright, 1996).

Most PTSD sufferers have high levels of anger which may result in violent outbursts and aggression (Nelson & Wright, 1996). Individuals with PTSD have higher rates of criminal behavior (Zatzick, et al., 1997). Traumatized urban residents may become involved with the criminal justice system by aggressively acting out to obtain control of their lives, create personal identity, and protect themselves, even carrying a weapon to restore feelings of safety (Anderson, 1999; Lopez, 2014; Corbin, Purtle, Rich, Adams, Yee, & Bloom, 2013). Many may use illegal

drugs to deal with trauma. Better engagement, assessment, and treatment will help individuals work through traumatic experiences and find direction within their lives (Ford & Blaustein, 2013).

Methodology

This research study included a survey of more than 100 male jail detainees and in-depth interviews of six men chosen from the larger sample. Study subjects were enrolled in the Integrated Multistage Program of Assessment and Comprehensive Treatment (IMPACT), based on a therapeutic community model that was modified for implementation in a secure jail setting. Administered by the WestCare Foundation, IMPACT provides intensive substance abuse treatment and other services to about 168 male detainees daily. Most of these detainees are awaiting court appearances to determine their case dispositions.

Phase one: Survey of detainees

A total of 117 Cook County jail detainees participated in the survey. In order to gauge the prevalence of trauma and mental health issues, three well-known validated and standardized tools were employed, including the Brief Jail Mental Health Screen (BJMHS), the Posttraumatic Stress Disorder Checklist – Civilian Version (PCL-C), and the Life Events Checklist (LEC). These are provided in *Appendices A*, *B*, and *C*, respectively.

The BJMHS accurately screens men with mental health illnesses in 73.5 percent of cases (Steadman et al., 2005).

Researchers then administered the PCL-C, one of the most commonly used PTSD screening tools (Elhai, Gray, Kashdan, & Franklin, 2005; Weathers, Litz, Herman, Huska, & Keane, 1993). This tool has been widely validated in studies across a wide range of populations (McDonald & Calhoun, 2010).

Third, researchers administered the LEC, a reliable evaluation of trauma exposure that has shown convergent validity with other instruments that assess exposure to traumatic events (Gray, Litz, Hsu & Lombardo, 2004).

The first phase of the study found 21 percent of the sample met the criteria for probable PTSD (Ruzich, Reichert, & Lurigio, 2014).

Phase two: Case studies

The six men selected for interviews were chosen from the larger sample to learn from those with indicators of mental health issues, symptomatic for probable PTSD, and with a high number of traumatic experiences in their life.

Table 1
Subject levels of scores on three measures

Subject*	Brief Jail Mental Health Screen (BJMHS)	PTSD Checklist-Civilian Version (PCL)	Life Events Checklist (LEC)
Victor	High	High	High
Robert	High	High	High
David	High	Low	High
John	High	High	Low
Anthony	High	High	Low
Scott	High	Low	Low

*Pseudonyms used

Researchers conducted the qualitative interviews in 2012 in the Cook County jail. Each interview took one to two hours. Both researchers were course-certified on protection of human subjects. The study was approved by an Institutional Review Board to protect human subjects of research. All subjects received a consent form that informed about the research, the risk and benefits, and their rights as a participant of the study. All signed and consented to the research. Due to the sensitive nature of the interviews, all were given a referral sheet for various services to take with them or they could talk to the jail counselor. Subjects shared personal accounts of their experiences and disclosed involvement with illegal and socially unacceptable activities, leading the researchers to believe they were being truthful during the interviews.

The interviews were audio-recorded and transcribed. All were analyzed using NVivo qualitative software.

Limitations

The qualitative interviews conducted in phase two allowed researchers to find out much more about a small number of individuals, but the information collected is not generalizable. Researchers conducted in-depth interviews with a small group of particular individuals. The sample contained six men who grew up in the Chicago; housed in the Cook County jail and participating in the jail's substance abuse program. All had indicators of mental health issues, traumatic events, and PTSD.

Case studies

Researchers interviewed six individuals with varying levels of mental health issues and PTSD. Their surveys indicated all were in need of further mental health assessment, four were symptomatic for probable PTSD, and three had experienced a great deal of trauma.

The men participating in the qualitative interviews ranged in age from 19 to 48 years old and averaged 30 years old. Three were Black, one was Middle Eastern, and two were Latino. They all grew up in Chicago.

The following narratives are based on the interviews. Pseudonyms rather than actual names were used.

Case study #1: Victor

Background

Victor was a 32 year old Hispanic male. He was born in Puerto Rico but moved back and forth between Puerto Rico and Chicago. Drugs, crime, and gunfire were common in the neighborhood where he grew up. In fact, he described the home he grew up in as being about 15 feet away from the "dope spot." He was raised by his mother and stepfather and neither were able to speak or hear. Also in the home were his two siblings and aunt. Victor's step- father beat his mother and used crack cocaine. While growing up, he felt that only his aunt loved him unconditionally.

When he was 12 years old, Victor joined a gang and started using cocaine and alcohol. Later, his primary drug of choice was heroin, which he injected daily. Despite his drug use and gang involvement, Victor finished high school and obtained an associate's degree. His longest period of employment was two-and-a-half years.

Victor has had periods of homelessness. He had to rely on "crashing" at friend's houses for shelter. The area he lived in prior to being jailed had a lot of gang activity, gunfire, crime, and drugs.

Victor has had two serious relationships but has never married. He has no children but reported that his girlfriend had a miscarriage. As an adult, he believes his aunt and his ex- girlfriend love him unconditionally.

Victor attempted suicide twice, once at age 15 and again at 18. He has been diagnosed with depression in the past. Victor also has significant medical problems. When he was 22 years old, he had a stroke and now has heart problems. He was recently diagnosed with Hepatitis C.

Trauma history

Victor has an extensive trauma history that began when he was just a child. He has been a victim of abuse and assault, witnessed violence, and even experienced a natural disaster.

Around age five, Victor was sexually abused by a male cousin. He also had unwanted sexual contact when he was 15 years old with a 32-year-old woman.

In addition to sexual abuse, Victor has been the victim of multiple violent acts. He was seriously physically assaulted twice, robbed at gunpoint, and shot. He was also stabbed while in jail in Puerto Rico. Victor shared that he was almost kidnapped at gunpoint but his mother accosted the kidnappers and he was let go. Moreover, Victor lost a family member to violence. When he was 12 years old, his oldest brother was killed.

Victor handled two dead bodies and saw two people killed. He witnessed the first murder when he was about eight or nine years old.

> "*The first one was -- I think this one traumatized me real bad. It was when I was a kid. I think I was like eight, nine years old. Me and my mom, my step-dad, my little brother and sister were coming from church. And it was nighttime. It was like 9 p.m. And we were parking in the parking lot in the project and I saw these guys from the project just dragging this lady by her hair. And one of them had a handgun. The other had like, I think it was like a MP1 on him, you know, like before, like a little machine gun. And she's screaming and, you know, fighting with them. But they just dragging her… And the guy that was holding the lady by her hair, he just put her down and boom, shot her in the head. I can still see her head just going like this and just dropping down. They just walk away, like they just killed a dog or, you know, something, like it was nothing for them. So yeah. That was the first time that I see somebody killed.*"

Victor was in two serious car accidents; the first was when he was 15 and another when he was 25 years old. He had his home broken into and experienced several hurricanes while living in Puerto Rico.

Adaptation to trauma

Victor scored high on the Brief Jail Mental Health Screen, PTSD Checklist, and Life Events Checklist.

Victor stated that after experiencing a traumatic event, his relationships with family or friends was impaired and he noticed a decreased intimacy or trust in others. He also reported nightmares and feeling edgy and anxious.

> "*Like for some reason most of the time, no matter if I'm in a safe environment, I'm kind of like edgy, skeptical, you know, like sometimes I'm getting anxious for no reason. Like right now, look. My hands start sweating really bad. Yeah. I lost a lot of sleep, nightmares, so bad that I remember when I was living with my girl, she used to wake me up and tell me that I used to say a lot of like crazy things in in my sleep.*"

Victor had never spoken openly about the traumas he has suffered. He used alcohol and drugs to cope and would sometimes turn to God.

Case study #2: Robert

Background

Robert was a 22-year-old Black male. He grew up in Chicago's Woodlawn neighborhood. Robert described this neighborhood as being infested with drugs and gangs. He said that there were often shootings on his block in his neighborhood. Nevertheless, he reported feeling relatively safe growing up there. Robert has continued to live in this neighborhood.

Robert was raised by his mother; he has three siblings and grew up with two of them. While growing up, his mother used 3 to 4 bags of heroin daily. Robert's father left when he was three and they had no further contact until Robert was 20 years old.

At 12 years old, Robert joined a gang and tried alcohol and marijuana for the first time. Prior to his current detainment, he used Xanax and alcohol daily and promethazine and codeine about every three days.

Robert had to repeat the 3rd grade and dropped out of school in the 11th grade. He reported being a bully and having a lot of fights in school. His longest period of employment was less than one month.

Robert has been in four serious relationships and has three children. He has always felt unconditional love from his mother and sister.

Trauma history

While just 22 years old, Robert has already experienced a considerable amount of trauma. The following chronological account gives an example of its pervasiveness.

Around age 4, Robert's home was broken into and the intruders hung his niece out of a window in front of him. He reported thinking that the men who did this were going to kill him and his family.

At age five, he saw his first dead body (one of three witnessed).

At age six or seven, he saw a woman stab his mother in the head with a butcher knife. He feared he was going to be killed during this event.

Around age seven, he saw his cousin get shot in the head and killed.

Between the ages of seven and eight, he saw a woman gruesomely killed. He shared:

> "*A car was chasing another car, shooting at them in the Woodlawn community. I was young. And he was trying to get away from--and a man was going like probably like 70, 80 miles an hour. And he had hit this old lady that was sitting in the park. She always sit in the park, read her book in Washington Park. And he had hit her and knocked half of her face off… her eyeball and stuff was hanging out*."

When Robert was eight years old, he witnessed his older sister stab her husband 10 times. His home was broken into, and he was forced to touch his mother's friend's private parts or had his touched under threat of force.

At age nine, he saw a man seriously beaten with a baseball bat, witnessed his mother's boyfriend physically assault her, and was in a serious car accident in which he and his mother hit a building.

At age 17, Robert was robbed at gunpoint for the first time. He has been robbed at gunpoint three times. He also experienced unwanted sexual contact.

At 18 years old, Robert was homeless for a period of time, his girlfriend had a miscarriage, and he was shot in the back. He estimated he has been shot at approximately 30 times; three of those times he thought he was going to die.

> "*Then I almost got killed, and so you know, like I was outside one day, and somebody had jumped out a car with a gun. So I had--I ran, but I slipped in the mud. And there's just the blessing from the Lord, 'cause he was reaching over the car looking up. I'm seeing the sparks from the gun. He's just reaching--he's reaching over the car and shooting at me. Blessing from the Lord.…He missed all 12 shots*."
>
> "*And then one time I was walking with my daughter, and somebody else had rode up on a bike shooting at me. I was walking with my daughter*."
>
> "*Another time when I was in the Woodlawn community, this boy was hanging out the window. He had one leg out the window. One- half his whole body was hanging out the window. He was on the passenger side of the car. He had a--he had a gun with a long clip on it, and he—he had shot up the block, and they bust a U-turn and came back and shot up the block again*."

When he was 19 years old, his sister killed someone while driving drunk, and he went to jail for the first time.

At 21, Robert watched his friend get shot in the head.

In addition, Robert shared that his youngest daughter was born with an enlarged heart and that he has been the victim of domestic violence, including being stabbed and hit over the head with a frying pan.

Adaptation to trauma

Robert scored high on the Brief Jail Mental Health Screen, PTSD Checklist, and Life Events Checklist. Robert reported having cold sweats and nightmares that could last for weeks at a time. He also stated that he felt diminished trust towards other people. He used alcohol and other drugs to cope with the things he has gone through. When he was in high school, he would swim to help with the trauma. He has talked to his mother and a friend about his experiences and he has shared a little during group therapy in the jail's drug treatment program. He expressed that he would like to talk about them more.

Case study #3: David

Background

David was a 21-year-old Hispanic male born in California. His family moved to Mexico when he was one year old and he lived there until he was 14 when he moved to Chicago.

When David was five years old, his parents separated and his mother took a job in another city. His grandparents raised him and his siblings and he had minimal contact with either of his parents. Growing up, he went one week without eating as his family did not have money for food.

David joined a gang at 14 years old and dropped out of high school in the 10th grade. He would frequently get into fights while in high school. Once he dropped out of school, he started selling drugs heavily. He first tried alcohol and drugs (marijuana) when he was 17 years old. Around age 20, he started using cocaine, eventually leading to daily use. He had one period of employment that lasted seven months.

David has never been married and has had one serious relationship that lasted two years; he does not have any children. As an adult, he feels that his mother unconditionally loves him.

Trauma history

David has been the victim of multiple acts of violence. As an adolescent in Mexico, he was attacked with a 4-by-4. He was physically assaulted one time with a bat and had his arm dislocated. He has been shot at about seven times, attacked with a knife, mugged, and kidnapped.

> "*One time I was coming from school, from high school. Guys from other gang grabbed me, put me inside the car and take me to a garage and they start hitting me and kidnapping me. Then they took my clothes and then just left me like that, without clothes*."

David had seen four people killed. He was in a gun fight in which his friend was killed and he had to handle the dead body.

When David was five years old, he was in a hurricane that destroyed his family's house and all their belongings. As a young adult, his home was broken into while he was there.

While detained at the Cook County Jail, both his six-month-old nephew and the grandmother who raised him died.

Adaptation to trauma

David scored high on the Brief Jail Mental Health Screen, low on the PTSD Checklist, and high on the Life Events Checklist.

David believes the traumatic experiences he endured negatively affected his schooling. He also noticed an increase in sleep after a traumatic event occurred and reported decreased intimacy or trust in other people. David contributed some of his criminal activity to his parent's separation, which he considered a traumatic event.

> "*Relationship with my father, my mom, after they got separated, I wanted to have like every child wanted have they family together, so actually I was looking for—to be close to somebody, you know, not being alone…That lead me to [gang] membership which led to all kinds of criminal activity and trouble*."

David reported that he used alcohol and drugs as a way to cope with the stressful events he experienced. He has talked nominally about the hurricane and his gang experience during group treatment sessions in the jail's drug treatment program.

Case study #4: John

Background

John was a 48-year-old Black male. He moved to Chicago's West side when he was about 4 years old. Gang activity, crime, gunfire, and drug dealing were common in this neighborhood. He grew up with his mother, father, and eight siblings. His father drank "a lot" of alcohol daily and later started using drugs. On occasion, his father would physically abuse his mother and his mother would fight back. His father was involved in criminal activity and when John was around age 10, his father would bring him along while he robbed stores. John shared that his mother was very strict. He described her disciplinary style in the following way:

> "*… if we don't do our homework, if we stay out too late, we get punished, we get whoopings. We was getting whipped like with stitching cords and tied to the chair, you know, so we can't run and stuff…*"

John completed the 10th grade and later obtained his GED. He joined a gang when he was 16 years old. His longest period of employment was about eight months. He has been homeless for periods of time and has had to "crash" at other people's homes for shelter. John first went to prison at 18 years old.

John tried drugs at the age 13 years old (sniffing glue). He reports regular use of heroin and cocaine when he's not in jail.

He has been in four serious relationships and has four children. John has been in his current relationship for 20 years but has never been married. He feels that his girlfriend loves him unconditionally.

John disclosed a diagnosis of major depression in the past.

Trauma history

John witnessed widespread violence in the neighborhood he grew up in. Around 10 years old, he said he was saw people being shot at, "*laying in puddles of blood*," and killed in the projects. Community violence extended into his adult life. John described the area he lived in as an adult as dangerous.

> "*It wasn't safe at all. I witnessed a lot of killing, right in front of me and that, so, I mean, it was like—it was like I would go to the store for some reason and come back. One of my friends that I be hanging with [would be] dead. Or I would go to jail and hear about two or three of my friends dead, guys I be hanging with*."

When he was 12 years old, John witnessed his father attack another man with a baseball bat. This assault resulted in his father's imprisonment. John relayed the following story:

> "*We was wondering what all the commotion is. Everybody's surrounding. And we couldn't see who was fighting. So me and my brother went and got involved just to see who was fighting. We saw it was our father. And we just was looking. He squeezed his arm, and the blood just skidded out. Then he looked around. He grabbed a bat, and he started chasing the guy. When he caught him, he hit the guy in the head real hard with the bat, 'cause it sounded awful. Everybody say, 'whoa.' But the guy, he didn't fall down. The guy just stood there and just looked at him. And then my dad just kept hitting him, kept hitting him, yeah. He didn't kill him, though*."

John has known 11 people that have been killed and witnessed six of their deaths. As a teenager, he saw his uncle's murder. This uncle acted as a surrogate father at times.

> "*He was—he used to take care of us when my father couldn't. He used to be there for us and come in there, come to his house, stay at his house. He used to teach us things, how to be respectful to other people, you know, to guide us in the right direction, 'cause my father couldn't really do it, because he didn't know how. Saw him get killed. I saw him actually get killed. He got shot… some gangbangers shot my uncle*."

John has also been a victim of physical violence. He has been assaulted, robbed at gunpoint, and shot at twice.

Adaptation to trauma

John scored high on the Brief Jail Mental Health Screen and the PTSD Checklist, but low on the Life Events Checklist.

John reported nightmares and trouble concentrating after experiencing a traumatic event.

> "*… I couldn't focus right… 'cause, you know, I would mostly think about some things, just pop up. I can be talking to somebody on a certain subject, and I be thinking about some tragic stuff that happened. And it always been like that. I can be talking in mind and think about something drastic, you know*."

John used drugs to cope with the violence he witnessed. He shared that he feels guilt in relation to the trauma he experienced. "*Cause I could have prevented a lot of stuff in my past and all, if I would have listened to the people that really cared about me*."

He has talked to friends and during group therapy at the jail's drug treatment program and found that to be useful.

> "*It helped me a lot 'cause it's like--it's like I'm releasing a lot of stuff, like cleaning out my garbage can, you know. Just dump it out, garbage out. Get it out. It feel good to just get it out.*"

Case study #5: Anthony

Background

Anthony was a 35-year-old Middle Eastern male who grew up in Chicago's Rogers Park neighborhood. He lived in this neighborhood until the age of 14 when he moved to Skokie, a northern Chicago suburb. He felt safe in Rogers Park and said while drugs were not widespread, public drinking and marijuana use were common. Crime and gangs also were common and he heard gunfire every day. His parents were married and he grew up in a two-parent household with his three siblings. His father owned a clothing store and worked a lot. Anthony described his relationship with his family as "awesome." Anthony reported there was no violence in his home; however, his father would physically discipline him.

> *"He would smack me around… till he thought he was done... and he busted my nose with a head butt."*

As a child, he felt that his parents and siblings loved him unconditionally.

At age 12, Anthony joined a gang. He first tried alcohol at 13 years old and drugs at 14 years old. The first drug he tried was marijuana followed shortly thereafter by cocaine. Cocaine continues to be his primary drug of choice. To get money to buy drugs, he would commit armed robbery or rob drug dealers. He has only ever committed a crime when he was high.

Anthony is a high school graduate. He was expelled from two high schools and completed his education at an alternative high school. Throughout high school, Anthony fought frequently, mainly with rival gang members. Anthony had periods of employment, starting in his father's store around age 13.

At age 20, Anthony was sent to prison for nine years.

Anthony has had one serious relationship but has never been married. As an adult, he feels that his parents, siblings, and girlfriend all love him unconditionally.

Trauma history

At seven years old, Anthony was sexually abused by his mother's friend. The abuse lasted for one or two years.

When he was 10 years old, the building his family lived in burned down in the middle of the night; everyone made it out alive.

At age 13, Anthony was "jumped" for the first time. He estimates he has been attacked about 10 to 12 times. Two of these assaults required emergency room visits and stitches. At 14 years old, he was assaulted so severely that he thought he was going to die.

Anthony had two close friends die before the age of 18: one from an overdose and another committed suicide. His friend's suicide led him to be hospitalized in a mental institution for two to three weeks.

> "*My buddy committed suicide. He blew his brains out. And I kind of went berserk*."

Anthony has seen people violently injured or killed and has also seen dead bodies. He has been attacked with knives and guns and estimated that he has been shot at approximately 80 times. Anthony recalled the following:

> "*One time was on Halloween. I think I was like 16 or 17. I was chased in an alley and I think a few of the rival gangs had me in a corner, just had the gun against me and—they spared my life. And that's why I became so black, angry, I guess*."

Adaptation to trauma

Anthony scored high on the Brief Jail Mental Health Screen and the PTSD Checklist, but low on the Life Events Checklist.

Anthony reported nightmares as well as decreased intimacy and trust towards other people. He thinks these traumatic events caused him to distance himself. He feels guilt about his friend's suicide and thinks he could have prevented it. He has never talked freely about the traumatic events he has experienced. He used drugs and alcohol to cope and noticed an increase in the amount he would use after something bad happened.

> "*I mean, it made me forget about it while I was high, but when there was none left or I was out, it made the situation worse*."

Case study #6: Scott

Background

Scott was a 19 year old Black male who grew up on Chicago's West side. Crime, drug dealing, gunfire, and gangs were common in the neighborhood where he was raised. During childhood, Scott lived with his mother and three sisters. Scott reported that he had a "very good" relationship with his mother and that she always provided for him. While Scott knew his father, he never lived in the home with them. Scott's father used drugs and beat his mother. As a child, he felt that his grandmother loved him unconditionally.

Scott first used drugs (marijuana) at age 13 and alcohol at 17 years old. He has since only used marijuana and alcohol. Scott joined a gang at the age of 14. He completed the 10th grade and stated that he was involved in a lot of fights at school. Scott has never had a job and he sold drugs for money. He started selling drugs at the age of 13.

Scott reported one serious relationship and has one child. As an adult, Scott stated that his mother, grandmother, and brother loved him unconditionally.

Trauma history

At age 16, Scott was in a car accident. While he was unhurt, the person in the other car was injured. He was smoking marijuana when the accident occurred.

Scott also reported being seriously injured a number of times as a result of gang fights, including being hit with a baseball bat. For his gang initiation, he was physically assaulted by 10 gang members resulting in a visit to the emergency room. Scott's cousin was shot in front of him. He has been threatened with a gun, he has seen dead bodies, and he has been robbed twice.

Adaptation to trauma

Scott scored high on the Brief Jail Mental Health Screen but low on the PTSD Checklist and Life Events Checklist.

Scott did not report any negative consequences from his traumatic experiences. He reported he would use "*more weed*" after something bad happened as a way to cope.

Discussion

Among those interviewed, community and domestic violence were widespread. As children, five of the six interviewees resided in a neighborhood where crime and gunfire were common and only two felt safe in their communities growing up. By adulthood, all six lived in dangerous urban neighborhoods. Household violence also was described by a number of interviewees. Half of those interviewed saw their fathers physically abuse their mothers as children. Three subjects experienced parental separation and three were abandoned by at least one of their parents.

Research shows that community and domestic violence often results in PTSD (Boston Children's Hospital/Harvard Medical School, n.d.). According to the Family Informed Trauma Treatment Center, "Families living in urban poverty often encounter multiple traumas over many years. Further, they are less likely than families living in more affluent communities to have access to the resources that may facilitate the successful negotiation of their traumatic experiences. Thus, many families have difficulty adapting," (Collins, Connors, Donohue, Gardner, Goldblatt, Hayward, Kiser, Strieder, & Thompson, 2010, p. i).

Just two of the interviewees graduated from high school. One interviewee went on to obtain his GED in adulthood. All six had significant romantic relationships at some point in their lives but none married. Three reported periods of homelessness. According to one study, homeless men had a high prevalence of depression, family dysfunction, trauma, substance abuse, and mental health (Kim & Roberts, 2003).

All subjects were drug users. Five subjects began using drugs and/or alcohol during early adolescence. Research has examined the relationship between substance abuse and trauma/PTSD for reasons of self-medication, common vulnerability/susceptibility, and the notion that one makes a person at high risk for the other (Gulliver & Steffen, 2010). Research has found that PTSD symptoms were associated with greater drug dependence symptoms (Ouimette, Read, Wade, & Tirone, 2010).

All six interviewees were gang members. One interviewee, David, talked about gang retaliation against him likely due to small "beefs" or perceived disrespect. According to Anderson, respect is a major role in how urban young men navigate the dangerous world in which they live (1999). Anderson called young men's aggressive reactions to disrespect, often violent ones, as a "code of the street," used to create personal identity and protect themselves.

Trauma affected the men in the case studies early and often. By the age of five, three interviewees had already experienced a traumatic event. Individuals who have experienced traumatic events are at higher risk for exposure to subsequent trauma and development of PTSD (Breslau, Davis, & Andreski, 1995; Schnurr, Spiro, & Paris, 2000). All individuals interviewed experienced a multitude of stressful or disturbing events. Witnessing the death or injury of another person, may result in PTSD symptoms (Breslau, Davis, & Andreski, 1995).

While men have varied trauma histories, direct and vicarious physical violence was commonplace among the interviewees. Among case study participants, all were physically

assaulted, shot at, and witnessed dead bodies. Most were robbed at gunpoint, stabbed, had witnessed a murder, and witnessed someone get seriously injured. In a similar study of 49 men in Boston, most had been shot (59 percent) or stabbed (35 percent), and 42 percent had been injured seriously in the past (Rich & Grey, 2005). In studies of male prisoners, the most commonly reported trauma is witnessing someone being killed or seriously injured (Sarchiapone, Carlia, Cuomoa, Marchettia & Roy, 2008), followed by physical assault (Johnson et al., 2006), and childhood sexual abuse (Weeks & Widom, 1998). Research indicates those most likely to experience victimization are people of color from single parent homes living in urban or disadvantaged neighborhoods (Siegfried, Ko, & Kelley, 2004).

All participants reported they thought they would be killed or seriously injured on at least one occasion. One's perception that their life or the life of a loved one is in danger is the defining feature of a traumatic experience (Miller, 2011).

While exposure to traumatic events can have a significant impact on an individual's physical and mental health (Pennebaker, 2000), few in this study reported mental illness and chronic or serious physical illnesses. Two interviewees were previously diagnosed with a mental illness although none reported having a current diagnosis for a mental illness. One attempted suicide and one had serious physical health conditions.

The interviewees had a range of reactions to the traumatic experiences they faced and all indicated they used alcohol or drugs as a way to cope with distressing experiences. This has serious implications given that all interviewees were participating in a substance abuse treatment program and that in the absence of alcohol or drugs, trauma symptoms may worsen (Loper, 2002). Furthermore, people with both PTSD and substance use diagnoses have poorer treatment outcomes than those without PTSD (Ouimette, Finney & Moos, 1999), suggesting that treatment programs need to tailor protocols for this population. It also indicates that offenders with co-morbid PTSD and substance use disorders need to acquire alternate ways to manage their trauma symptoms if they wish to remain sober.

Implications for policy and practice

Practitioners can better recognize, screen, and assist men experiencing PTSD as a result of their exposure to urban violence and their experiences as both victims and perpetrators of crime. Further understanding and treatment will go a long way in helping individuals heal from trauma and experience better public health outcomes.

Offer treatment to male trauma survivors in and out of custody

None of the interviewees received professional help for PTSD and few mentioned using positive coping skills. In fact, just one person reported that he had ever talked openly about some of his trauma history. Research found only 13 percent of low-income Blacks with PTSD in urban neighborhoods received prior trauma-focused treatment (Davis, Ressler, Schwartz, James Stephens, & Bradley, 2008).

Research has shown that individuals have a lower chance of developing chronic PTSD with early treatment following a traumatic event (Litz & Maguen, 2007). In addition, treating offenders may reduce recidivism. Researchers found mental illness symptoms and certain types of abuse—adult sexual abuse and intimate partner violence—to be risks factors for recidivism (Van Voorhis, Salisbury, Wright, & Bauman, 2008). In- and out-of-custody treatment programs can effectively help offenders manage and cope with their trauma histories.

Screening

Few are screened for trauma-related symptoms or given trauma-informed care when they enter the juvenile justice or criminal justice systems (Adams, 2010). In one study, researchers administered a four-item screening tool, Primary Care PTSD (PC-PTSD), at a Chicago trauma center and found 42 percent of participants had a positive screen for PTSD (Reese et al., 2012). They found those with gunshot wounds were 13 times as likely as those injured by falls and twice as likely as those involved a motor vehicle crash to attest positive for PTSD. A majority of those with PTSD assessments noted it would be helpful to talk to someone. The PC-PTSD could be used in various settings for victims and their families. Other trauma-screening tools available include Childhood Adversity Screening, Traumatic Stress Symptoms UCLA PTSD Reaction Index, and Global Appraisal of Individual Needs–Short Screener (GAINS-SS) (Vooris, 2015).

Trauma-informed approach

A trauma-informed approach includes trauma-specific interventions or treatments designed specifically to address trauma and can be implemented in any type of service setting or organization, according to Substance Abuse and Mental Health Services Administration (SAMHSA) (2015).

According to SAMHSA, a trauma-informed program or system:

- Realizes the widespread impact of trauma and understands potential paths for recovery.

- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system.
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices.
- Seeks to actively resist re-traumatization.

SAMHSA’s six key principles of a trauma-informed approach are:

- Safety.
- Trustworthiness and transparency.
- Peer support.
- Collaboration and mutuality.
- Empowerment, voice, and choice.
- Cultural, historical, and gender issues.

Criminal justice practitioners, including those working in corrections, can help stabilize offenders, minimize triggers, de-escalate situations, and avoid practices that may repeat aspects of past abuse, such as restraint and seclusion (Miller & Najavits, 2012). Correctional officers may encounter inmates who have experienced multiple traumas; these officers should be trained on trauma-informed care. Overall, higher rates of trauma and earlier age of trauma onset are associated with increased violence and victimization in prison (Komarovskaya, 2009).

John Hopkins Urban Health Institute recommends the following to develop a trauma-informed justice system:

- Offer crisis intervention training for police departments, training for first responders and all involved.
- Screen for trauma upon arrest.
- Provide appropriate care in the system to prevent of further traumatization.
- Collaborate across systems to determine placements and referral to services.
- Offer adequate and appropriate services for individuals in the criminal justice system.
- Provide support for criminal justice workers including vicarious trauma.
- Increase public awareness about the role that trauma plays in the criminal justice system (Vooris, 2015).

Treatment

Urban residents do not access treatment for PTSD due to limited transportation and money, family disapproval, and unfamiliarity with accessing treatment (Davis, Ressler, Schwartz, James Stephens, & Bradley, 2008). The following can be used in community-based treatment settings—cognitive–behavioral therapy, relapse prevention, social skills training, motivational interviewing, 12-step facilitation, individualized drug counseling, community-reinforcement approach plus vouchers, and contingency management (Wallace, Conner, & Dass-Brailsford, 2011).

PTSD symptoms may negatively impact an individual's ability to benefit from even the most effective treatment programs (Miller, 2011). Individual cognitive behavioral therapies (CBT) are now seen as the best first-line treatment for PTSD (Foa, Keane, & Friedman, 2000), but can be cost prohibitive for many. When that is the case, individual-format therapies can be adapted for use in a small group format with the added benefit of a natural support group (Beck & Coffey, 2005). One study found group CBT offered promise as an effective treatment of PTSD (Beck & Coffey, 2005).

Co-occurring disorders

In this study, all of the men were drug users, most starting in adolescence. Research has shown strong co-morbidity with trauma and substance abuse (Breslau, Davis, & Schultz, 2003; Reed, Anthony, & Breslau, 2007). One study of an urban population in an urban city found strong links between childhood traumatization and substance abuse and their relationships to PTSD (Khoury, Tang, Bradley, Ressler, 2010).

An urgent need exists to treat co-occurring trauma, mental illness, substance abuse, and behavioral problems (Wallace, Conner, & Dass-Brailsford, 2011; Kim & Roberts, 2003). Historically, the standard was to treat substance abuse first followed by trauma/PTSD (sequential model). Today, best practices indicate they should be treated simultaneously with an integrated model (Ouimette, Read, Wade, & Tirone, 2010). Integrated models recognize the interplay between the two issues and have shown to have better results.

Research indicates PTSD and substance abuse disorder can be treated using an exposure-based form of cognitive behavioral therapy allowing the patient to emotionally engage and process the traumatic memories in the absence of feared outcomes (Foa, Hembree, & Rothbaum, 2007).) Practitioners need more training not only in evidence-based treatments but also to address misperceptions regarding treatment (Van Minnen et al ., 2010). According to Gulliver and Steffen, clinicians and researchers must work quickly to develop and implement best practices for co-occurring PTSD and substance abuse disorders (2010).

Increase awareness of male survivors of urban trauma

Trauma is not just a female, overseas, or war veteran phenomenon. As these case studies point out, trauma affects men growing up in American inner cities and urban areas. Public awareness of the prevalence of trauma in urban males, particularly among service providers and criminal justice system practitioners, is needed.

Urban males who come to the attention of service providers after a traumatic event are rarely referred to mental health services (Rich & Grey, 2005). According to Rich and Grey, "Lack of insurance coverage and lack of culturally competent mental health services make it difficult for those who are in distress to find treatment. Effective treatment of symptoms could potentially interrupt a cascade toward weapon carrying, substance abuse, and further alienation from stabilizing institutions such as employment, education, and health care" (2005, p. 823).

Trauma is not regularly recognized in the justice system (Adams, 2010). In one study, focus groups of juvenile court judges from across the country found half received no training on trauma and were unaware of symptoms, diagnoses, and treatments for trauma (Sprague, 2008).

Conduct further research on urban trauma

Finally, more research is needed to understand prevalence of trauma within specific populations and individuals, identify those most at risk for PTSD, and develop best practices to identify and treat survivors of urban violence. Future studies involving multi-method, prospective approaches on trauma of urban men can increase understanding of this phenomenon (Rich & Grey, 2005).

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Appendix A: Interview questions and areas of discussion

DEMOGRAPHICS

- Date of birth, age
- Ethnicity/race

FAMILY HISTORY

- Place of birth
- Neighborhood- safe, drug dealing, crime, gangs, gunfire
- Primary caregiver (foster care), parent job
- Relationship with family members
- Parent's relationship
- Siblings
- What type of housing did you grow up in?
- How raised/disciplined/ punished
- Provided for- food, clothing?
- Household organized, chaotic, abusive
- Parent criminality, drug use
- As a child, did anyone unconditionally love you and support you who you could trust?

EDUCATIONAL HISTORY (High school and beyond only)

- Relationship with/ problems with teachers, students, fights, bullying
- Attendance/ truancy, tardy
- Detentions, suspensions, expulsions
- Repeat grades, special education
- Last grade completed
- Number of high schools attended
- Attitude toward school
- Friends, gang activity

MILITARY HISTORY

- Enlisted, drafted, ROTC
- Rank achieved
- Combat experiences
- Disciplinary action

EMPLOYMENT HISTORY

- Longest period of full/ part time employment as adult
- Why left job? Fired, quit, why?
- Relationship with coworkers, supervisors
- Most recent employment

MARITAL/ RELATIONSHIP HISTORY

- Number of marriages, significant relationships, length of relationships
- Separations, divorces
- Children- relationship, custody, problems physical, mental health
- Current significant other
- As an adult, do you have anyone in your life you feel loves you unconditionally? Do you currently?
- In the 6 months prior to coming to jail did you have anyone you could really count on and trust?

ENVIRONMENT AND SOCIAL FACTORS

- Where resided before jail? Neighborhood?
- Type of residence, live by self or roommates?
- Presence of gangs
- Availability of drugs
- Feel safe
- Frequency of gunfire
- How spend free time?
- Have you ever been homeless (as child, adult)?

MEDICAL HISTORY

- Current physical health status
- Any serious, chronic illnesses
- Any head injuries?
- Emergency room visits?

ALCOHOL/DRUG USE HISTORY

- Age at first use- alcohol? drugs?
- Primary drug of choice
- Have you put yourself in risky or dangerous situations to obtain/use drugs/alcohol?
- Have you put yourself in risky or dangerous situations while under the influence of drugs/alcohol?

MENTAL HEALTH HISTORY

- Ever been told had mental health disorder by mental health professional?
- When were you told this?
- When did symptoms start?
- Take medications to control your disorder?
- Had overnight hospital stay for mental health problem?

TRAUMA HISTORY

Ever experienced the following? If yes, when?

Have you ever experienced…

- Serious accident at work, in a car or somewhere else?

- Any other situation in which you were seriously injured?
- A situation in which you feared you might be killed or seriously injured?
- Seeing someone seriously injured or violently killed?
- Seen dead bodies (other than at a funeral) or had to handle dead bodies for any reason?
- Direct combat experience in a war
- Any use force or the threat of force, such as a stick-up or mugging?
- Attempted to rob you or actually robbed you (i.e. stolen your personal belongings)?
- Anyone attempted to or succeeded in breaking into your home when you weren't there?
- Has anyone ever tried to or succeeded in breaking into your home while you were there?
- A serious or life-threatening illness?
- Natural disaster such as hurricane, tornado, major earthquake, flood, or other disaster?
- A "man-made" disaster such as a train crash, building collapse, bank robbery, fire, etc., where you felt you or your loved ones were in danger of death or injury?
- Physical assault or abuse in your adult life by your partner?
- Physical assault or abuse in your adult life by someone other than your partner?
- Physical assault or abuse as a child?
- Seeing people hitting or harming one another in your family when you were growing up?
- Intercourse, oral or anal sex against your will as a child or teenager? Relationship to person?
- Intercourse, oral or anal sex against your will or rape in your adult life? Relationship to person?
- Someone touched private parts of your body, or made you touch theirs, under force or threat? Relationship with person?
- Any other situations in which another person tried to force you to have unwanted sexual contact?
- Anyone, including family members or friends, ever attacked you with a gun, knife, or some other weapon?
- Has anyone, including family members or friends, ever attacked you without a weapon and seriously injured you?
- Have you ever had a close friend or family member murdered or killed by a drunk driver? Specify relationship.
- Losing a child through death?
- Loss of a parent or someone who was like a parent to you before age 18?
- Loss of a spouse, partner, or loved one as an adult?
- Any other terrible or frightening thing happens to you?

ADAPTATION TO TRAUMA

- After the traumatic event, did you have any impaired work, school performance?
- Did you have impaired relationships with family, friends?
- Did you notice physical changes—weight loss, gain, illness, nightmares, sleep, heart racing, etc.
- Did you notice decreased intimacy and lowered trust in others?
- Do you think criminal activity is related to your trauma?
- Do you blame someone/something for your trauma?

- Feel any guilt, shame regarding trauma events?
- Ever talk to someone about traumatic events (i.e. friends, family)??
- Ever seek professional help to deal with traumatic events?
- Did you keep a journal or write your feelings down?
- Did you meditate or try relaxation exercises like yoga, stretching, massage?
- Did you seek out/ turn to God, spiritually, religion?
- Did you use drugs/alcohol or increase use to feel better after the traumatic event?
- Do you ever talk about trauma in group or with your counselor in Cook County jail?
- Did you do anything else order to deal with it?
- Find anything positive gained from your traumatic experience?

EXPERIENCES WITH CJ SYSTEM

- Describe experiences/interaction with police? Probation officers? Jail staff? Corrections/prison staff?
- Any violence or abuse while incarcerated?
- How long have you been in Cook County jail?
- Do you get along with other jail detainees? Any fights? Discipline?
- Safety and security: Ever fearful? Harmed? Concerned?

Any other comments that you would like to share?

Appendix B: Brief Jail Mental Health Screen (BJMHS)

For each question check one of the boxes to the right to indicate that Yes or No. If you do not want to answer, write REFUSE in the General Comments and explain why. If you "DON'T KNOW" the answer write DON'T KNOW in the General Comments and explain why.

Questions	No	Yes	General Comments
Do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
Do you currently feel that other people know your thoughts and can read your mind?			
Have you currently lost or gained as much as two pounds a week for several weeks without even trying?			
Have you, your family, or a friend noticed that you are currently much more active than you usually are?			
Do you currently feel like you have to talk or move more slowly that you usually do?			
Have there currently been a few weeks when you felt like you were useless or sinful?			
Are you currently taking any medication prescribed for you by a physician for any emotional or mental health problems?			
Have you ever been in a hospital for emotional or mental health problems?			

Appendix C: PTSD Checklist-Civilian Version (PCL-C)

Below is a list of problems and complaints that individuals 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.

Responses	**Not at all (1)**	**A little bit (2)**	**Moderately (3)**	**Quite a bit (4)**	**Extremely (5)**
Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?					
Repeated, disturbing dreams of a stressful experience from the past?					
Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?					
Feeling very upset when something reminded you of a stressful experience from the past?					
Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?					
Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?					
Avoid activities or situations because they remind you a stressful experience from the past?					
Trouble remembering important parts of a stressful experience from the past?					
Loss of interest in things that you used to enjoy?					
Feeling distant or cut off from other people?					
Feeling emotionally numb or being unable to have loving feelings for those close to you?					
Feeling as if your future will somehow be cut short?					
Trouble falling or staying asleep?					
Feeling irritable or having angry outbursts?					
Having difficulty concentrating?					
Being "super alert" or watchful or on guard?					
Feeling jumpy or easily startled?					

Appendix D: Life events checklist (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right. Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not sure	Doesn't apply
Natural disaster (for example, flood, hurricane, tornado, earthquake)					
Fire or explosion					
Transportation accident (for example, car accident, train wreck, plane crash)					
Serious accident at work, home, or during recreational activity					
Exposure to toxic substance (for example, dangerous chemicals, radiation)					
Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
Other unwanted or uncomfortable sexual experience					
Combat or exposure to a war-zone (in the military or as a civilian)					
Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
Life-threatening illness or injury					
Severe human suffering					
A sudden, violent death (for example, homicide, suicide)					
Sudden, unexpected death of someone close to you					
Serious injury, harm, or death you caused to someone else					
Any other very stressful event or experience					

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