Journal of Traumatic Stress
January 2021, *0,* 1–14

ISTSS International Society for Traumatic Stress Studies

Posttraumatic Distress and Treatment Barriers Among Former Gang Members: Implications for Improving Access to Traumatic Stress Resources in Marginalized Populations

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Limited research has examined the links among violent victimization, mental health, and service utilization among gang-involved individuals. This mixed-methods preliminary study examined narratives of psychiatric distress, current psychiatric morbidity, and mental health treatment experiences among a sample of former gang members ($N = 32$; M age = 44.4 years, 87.5% male; 56.3% Hispanic or Latino, 31.3% African American). Participants completed online questionnaires to assess trauma exposure and current psychiatric symptoms as well as a semistructured interview to examine histories of psychiatric distress and mental health treatment. Participants reported exposure to an average of 10.2 discrete traumatic events (range: 3–21). On average, participants reported exposure to five to six community violence–related events, ranging from never or one time up to monthly and weekly exposure. Participants generally described histories of depression, anxiety, posttraumatic stress disorder (PTSD), and substance abuse, although a thematic analysis revealed PTSD symptoms predominated the psychiatric distress described, including symptoms related to intrusions, avoidance, negative alterations in cognitions and mood, and alterations in arousal. Grounded theory analysis revealed barriers to traditional models of mental health treatment included self-isolation, gang rules, and social stigma, especially in the context of interpersonal disconnect with providers. Given conditions of limited resources to access treatment, participants engaged in peer support services, which may have reduced their psychiatric distress to currently low levels. Implications for understanding these notable findings of recovery and resilience for some individuals and building trauma-informed communities that improve access to traumatic stress resources for marginalized populations are discussed.

Research on gang members has traditionally focused on their offending behaviors, espousing a one-dimensional perspective that gang-involved individuals are solely violent perpetrators (Beresford & Wood, 2016). Indeed, the findings from one study demonstrated that compared to their at-risk youth counterparts, gang members were 20 times more likely to commit a drive-by shooting, 10 times more likely to commit homicide, four times more likely to assault a rival, and three times more likely to assault their own friends (Huff, 1998). More recently, research has indicated gang-involved individuals are also vulnerable victims (Beresford & Wood, 2016). Ironically, the most likely victims of gang violence are other gang members (Katz et al., 2011), suggesting an increased risk for both violent perpetration and violent victimization. In fact, in one study of 909 recently booked juvenile arrestees, violent victimization increased with gang-affiliated centrality: The prevalence of violent victimization was highest among gang members, followed by former gang members, then gang associates, and, finally, non–gang members, who were at the lowest risk (Katz et al., 2011). Compared to their non–gang member counterparts, gang members report higher levels of violence exposure (i.e., experiencing and witnessing community violence, living in a "war zone," seeing a dead body, unwanted sexual experiences among females) and perpetration-induced traumatic experiences (i.e., doing or being forced to do something very scary, dangerous, or violent to another person; Kerig et al., 2016) as well as witnessing violence against others, including the use of deadly force (Li et al., 2002). Further, intragroup violence (e.g., violent initiation rituals when entering or exiting a gang, violence to reprimand gang members who break gang rules) are normative features of gang life (Decker & Van Winkle, 1996).

Such violence exposure, both witnessed and perpetrated, among gang members unsurprisingly places them at a higher risk of psychiatric distress compared to non–gang members (Beresford & Wood, 2016). Two cross-sectional studies in the United Kingdom examined psychiatric morbidity and found a marked gradient in rates of psychiatric morbidity across three groups wherein psychiatric morbidity increased progressively

This research was funded by the California State University, Monterey Bay Faculty Incentive Grant awarded to Christine Valdez. The author has no conflicts of interest pertaining to this research.

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DOI: 10.1002/jts.22651

from nonviolent men to violent non–gang members to gang members, with the latter exhibiting the highest levels of anxiety, psychosis, antisocial personality disorder, substance abuse, self-harm, suicidal behavior, gambling, and problematic usage of pornography addiction (Coid et al, 2013; Wood et al., 2017). Thus, there appears to be a unique clinical presentation among gang members compared to violent and nonviolent men that may be conceptualized as a response to trauma. For example, one study demonstrated that perpetration-induced trauma (i.e., doing or being forced to do something very scary, dangerous, or violent to another person) was associated with posttraumatic stress and mediated the relation between gang membership and posttraumatic stress (Kerig et al., 2016). Another study found that violence exposure and delinquency mediated the association between gang membership and suicidal behavior, and the authors theorize that undetected posttraumatic stress disorder (PTSD) may contribute to the higher rates of suicidal behavior in gang members (Madan et al., 2011). This heightened risk for psychiatric distress among gang members may result from relationships with aggressive and/or delinquent peers who encourage witnessing violence and confronting, in kind, the victimization they experience, which previous research has suggested may amplify the association between violence exposure and internalizing symptoms (Rosario et al., 2008).

The increased psychiatric morbidity (i.e., the presence of a psychiatric disorder or significant mental health challenge) observed in gang members may explain the finding from one study that gang members were more likely to access psychiatric services than violent non–gang members and nonviolent men (Coid et al., 2013). However, it is important to note this study was conducted in the United Kingdom, where universal healthcare is available, and increased healthcare accessibility may have contributed to this finding. In their study, Coid and colleagues (2013) found that the high levels of consultations with psychiatrists or psychologists reported among violent men and gang members could be accounted for by these participants' fear of and experiences with violent victimization. Moreover, victimization and the fear of victimization mediated the association between gang membership and anxiety. These variables, together with violent rumination (i.e., repetitive thoughts about perpetrating violence), explained the high rates of admission to psychiatric hospitals among violent men and gang members in Coid et al.'s (2013) sample. Taken together, research suggests gang members show inordinately high levels of trauma exposure and psychiatric morbidity and have a higher degree of need for mental health services, underscoring the importance of trauma-informed care for this population. Yet, Beresford and Wood (2016) argue that the examination of gang membership and psychopathology are lagging globally behind other gang-related topics and call for a deeper understanding of gang dynamics and mental health to aid in formulating theory and conducting research to evaluate and develop effective interventions.

The purpose of this preliminary study was to utilize a concurrent mixed-methods design to replicate and extend previous research on gang-member trauma exposure, psychiatric morbidity, and service utilization among former gang members in the United States that could be used to inform theory, research, policy, and practice regarding the mental health needs of this population. The aims of the present study were to assess the rates of trauma exposure and current levels of distress. A related aim was to examine participants' narratives of distress and mental health treatment. Finally, this study aimed to examine narratives of service utilization to generate a theory, grounded in the data, to explain the trajectory of past psychiatric distress to current distress as a function of service utilization.

Method

Participants

In total, 32 gang members from the Western region of the United States participated in quantitative data collection, and 28 of these participants provided qualitative data. The average age of participants was 44.44 years ($SD = 10.64$, range: 25–64 years). The average age of gang entry was 15.06 years ($SD = 4.27$). Moreover, the length of gang membership averaged 17.38 years ($SD = 10.62$), and the average number of years since gang membership was 12.09 ($SD = 9.98$; range: 0–34). The sample comprised mostly men (87.5%, $n = 28$). With regard to sexual orientation, most participants were heterosexual (93.8%, $n = 30$), one participant was gay (3.1%), and one declined to answer (3.1%). Relationship status was reported as single (34.4%, $n = 11$), dating (18.8%, $n = 6$), living with partner (3.1%, $n = 1$), married (25%, $n = 8$), widowed (3.1%, $n = 1$), divorced (12.5%, $n = 4$), and separated (3.1%, $n = 1$). Most participants were of Hispanic or Latino ethnicity (56.3%, $n = 18$), whereas 14 participants reported they were not Hispanic or Latino or did not know (43.7%). Participants reported their race as African American (31.3%, $n = 10$), Caucasian or White (21.9%, $n = 7$), Biracial (9.4%, $n = 3$), American Indian/Alaskan Native (6.3%, $n = 2$), and Asian (3.1%, $n = 1$), and nine individuals did not specify or reported unknown race (28.1%). Almost half of the sample had some college or university experience (43.8%, $n = 14$), whereas 37.5% had a high school diploma or general education degree ($n = 12$), and six people had completed fewer than 12 years of school (18.8%). Most participants were employed full-time (46.9%, $n = 15$) or part-time (9.4%, $n = 3$), 11 were unemployed (34.4%), two were unemployed students (6.3%), and one participant declined to answer (3.1%). The majority of participants reported having an income of $25,000 (USD) or less (65.7%, $n = 21$), two participants reported an income of $25,001–$35,000 (6.3%), two participants reported an income of $35,001–$50,000 (6.3%), four participants reported an income of $50,001 or more (12.5%), and three people declined to answer (9.4%). Three participants (9.4%) were unreachable for a follow-up telephone interview, and one participant's telephone interview was inaudible, resulting in 28 participants for the qualitative analyses.

Procedure

This preliminary study aimed to recruit approximately 30 former gang members, as it has been suggested that 20–30 participants are needed for grounded theory methodology to achieve a well-saturated theory (Creswell & Poth, 2018). For the present mixed-methods research study, former gang members aged 18 years and older were recruited from community programs and organizations across the United States that serve and engage former gang members. Participants were recruited through research announcement flyers posted at relevant community organizations and through case managers as well as via snowball sampling throughout the United States. Potential participants called the research lab to inquire about the research opportunity; during this phone call, they were screened by research staff to determine eligibility (i.e., age 18 years or above and a former gang member). Individuals who were eligible to participate provided an email address to receive a link to the online self-report questionnaire as well as a telephone number to be contacted for a phone interview. The online questionnaire was hosted by Qualtrics (Provo, UT) online survey software. Participants provided informed consent online by clicking the appropriate button that directed them to the online study questionnaires. Once participants completed the online questionnaires, they were contacted by research staff to schedule a semistructured telephone interview, which was conducted by either the author or a trained research assistant (RA).

During the semistructured telephone interview, participants were asked nine structured questions, with response options that were both open-ended (e.g., "How have these [traumatic] experiences impacted your life? How did you cope with these feelings?") and closed-ended (e.g., "Have you seen a doctor, counselor, or therapist for any of these kinds of problems"?). Unstructured follow-up questions (e.g., "Tell me what it was like seeing the doctor/counselor/therapist?," "Tell me why you did not see a doctor/counselor/therapist?," "How did you feel after these [traumatic] events? Can you speak about how these [traumatic] events affected you?") were asked for clarification.

After interview completion, participants were reimbursed with an eGifter Choice Card, which was sent to the email address and cell phone number they provided, to redeem $50 in gift cards. This study was approved by California State University, Monterey Bay's committee on human research. No adverse events were reported.

Measures

Trauma Exposure

The Traumatic Life Events Questionnaire (TLEQ; Kubany et al., 2000) is a 23-item, broad-spectrum measure of trauma exposure that was utilized because it provides a more comprehensive assessment of trauma compared to other trauma history checklists (e.g., the Life Events Checklist for *DSM-5*; Weathers et al., 2013b). Items ask respondents to identify how many times they have experienced a potentially traumatic event, with responses rated on a scale of 0 (*never*) to 6 (*more than 5 times*). The TLEQ was adapted in this study to specify whether the traumatic experience occurred during gang membership.

Community Violence

The Survey of Exposure to Community Violence–Short Form (SECV-SF; Richters & Saltzman, 1990) is a 24-item measure of the frequency of an individual's exposure (i.e., victimization and witnessing) to violence in their home and community. Item content includes gang violence, selling drugs, police arrests, and assaults. As only one TLEQ item assesses community violence, this questionnaire was utilized to provide a comprehensive assessment of community violence exposure during participants' lifetime. Respondents are asked to identify how many times they have experienced, witnessed, or heard about each type of violence (e.g., "How many times have you seen someone else get chased by gangs or older kids?"), with response options ranging from 0 (*never*) to 8 (*almost every day*). Item scores are summed to generate a single score that indicates the extent of community violence exposure.

Posttraumatic Stress Symptoms

The PTSD Checklist (PCL) for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*; *DSM*-5), or the PCL-5 (Weathers et al., 2013), is a 20-item assessment of past-month posttraumatic stress symptoms. Symptom cluster severity scores can be obtained by summing scores for the items within a given cluster, with subscales for intrusions (five items), avoidance (two items), negative alterations in cognitions and mood (seven items), and alterations in arousal and reactivity (6 items). Items are rated on a scale of 0 (*not at all*) to 4 (*extremely*). A severity score is obtained by summing the scores from each of the 20 items. A score of 33 is recommended as a clinically significant cut-point for PTSD-positive participants (Wortmann et al., 2016). The PCL-5 has demonstrated adequate internal consistency, ranging from .91 in a sample of treatment-seeking military service members (Wortmann et al., 2016) to .94 in a college sample (Blevins et al., 2015). In the present sample, the internal consistency in this sample was excellent, Cronbach's $\alpha = .95$.

Depression

The nine-item Patient Health Questionnaire (PHQ-9; Kroenke & Spitzer, 2002) is a self-report measure of depression symptoms. Participants are asked to rate if they have been bothered by each symptom (e.g., "little pleasure or interest in doing things") in the past 2 weeks, scoring responses on a scale of 0 (*not at all*) to 3 (*nearly every day*). A total severity score is obtained by summing the scores from each item. Cut-points of 5, 10, 15, and 20 or higher are used to identify mild, moderate, moderately severe, and severe depression, respectively. The PHQ-9 has demonstrated adequate sensitivity (.77–.88), specificity (.88–.94), and internal consistency (Cronbach's αs $=$ .86–92) in several different samples (Kroenke et al. 2010). In the present sample, Cronbach's alpha was .83.

Generalized Anxiety

The Generalized Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006) is a seven-item, self-report assessment of generalized anxiety symptoms. Items ask participants to rate if they have been bothered by each symptom (e.g., "being so restless that it's hard to sit still") in the past 2 weeks, with responses scored on a scale of 0 (*not at all*) to 3 (*nearly every day*). A total severity score is obtained by summing the scores from each item. Cut-points of 5, 10, and 15 are used to identify mild, moderate, and severe anxiety. The GAD-7 has demonstrated adequate sensitivity (.89) and specificity (.82; Kroenke et al., 2010). In the present sample, Cronbach's alpha was .92.

Alcohol Use

The Alcohol Use Disorders Identification Test-10 (AUDIT-10; Saunders et al., 1993) is a 10-item, self-report screening tool used to assess past-year alcohol consumption and related problems. Items ask participants to identify the quantity (e.g., "How many drinks containing alcohol do you have on a typical day when you are drinking?") and frequency (e.g., "How often do you have a drink containing alcohol?") of alcohol consumption, drinking behavior, and alcohol-related problems or reactions (e.g., "How often during the last year have you been unable to remember what happened the night before because you had been drinking?"), with responses scored using a point system that ranges from 0 to 4 and totaled to create a severity score. Total scores range from 0 to 40, with a score higher than 8 indicating an alcohol problem. The AUDIT-10 has demonstrated adequate sensitivity (.90) and specificity (.92) in U.S. samples (Saunders et al., 1993). In the present sample, the internal consistency in the present sample was adequate, Cronbach's $\alpha = .87$.

Drug Use

The Drug Abuse Screening Test-10 (DAST-10; Skinner, 1982) is a 10-item, self-report screening tool to assess past-year drug use (e.g., "Have you used drugs other than those required for medical reasons?") and drug use–related problems (e.g., "Have you had 'blackouts' or 'flashbacks' as a result of drug use?"). Response options are "no" (0) or "yes" (1), with a maximum possible score of 10. Scores of 3 or more indicate the likelihood of drug abuse. The DAST-10 has demonstrated internal consistency ranging from .86 in psychiatric outpatients to .94 in newly admitted psychiatric patients (Yudko et al., 2007). In the present sample, the internal consistency was adequate, Cronbach's $\alpha = .86$.

Data Analysis

Data were triangulated such that quantitative and qualitative data were collected simultaneously during a single study phase in this concurrent mixed-methods design (Creswell & Zhang, 2009). Self-report measures were used to assess trauma exposure and current levels of distress, and semistructured interviews were used to assess idioms and experiences of distress. Data were triangulated in this way to examine how trends in quantitative self-report measures and qualitative lived experiences corroborated the literature or diverge or contradicted each other.

Quantitative data was exported from Qualtrics online survey software into SPSS (Version 24), which was used for all statistical analyses. Descriptive statistics were computed to examine exposure to trauma and community violence as well as current levels of psychiatric distress. Qualitative data were gathered through participant interviews that were audio-recorded and later transcribed by a trained RA. These audio transcriptions were reviewed by two separate RAs to ensure accuracy with the audio-recording.

Thematic Analysis

Thematic Analysis (Braune & Clarke, 2006) was used to examine mental health symptoms. Symptom codes were derived from the data using inductive analysis, in which two independent RAs read each transcript and identified significant phrases and sentences that pertained to symptom experiences. The RAs formulated meanings from these statements and phrases into codes common to all participants' transcripts. The author and the RAs met to critically assess the symptom codes that were identified to reach group consensus and develop a definition of superordinate themes anchored in participant narratives. The author, a licensed clinical psychologist, abstracted the data by reviewing symptom codes to forge connections and establish superordinate themes that denoted the diagnostic criteria represented in the current nosology of mental disorders from the *DSM-5* (American Psychiatric Association [APA], 2013). Interviews were independently rereviewed by the RAs to ensure all data sufficiently fit into the coding scheme, using a deductive process. After the second round of coding, the author met with the RAs to reach a consensus on symptom themes.

Grounded Theory

Data were further triangulated by extending the qualitative examination of psychiatric distress, using grounded theory methodology to analyze treatment experiences (Glaser & Straus, 1967) to understand participants' trajectories of distress. Grounded theory procedures for analysis consist of three phases of coding: open, axial, and selective (Strauss & Corbin, 1990). The method of constant comparative analysis was used to begin to identify codes that emerged from the data, using inductive strategies during open coding. Interviews were then rereviewed to ensure all data sufficiently "fit" into developed codes (Strauss & Corbin 1990), and a central phenomenon of interest was selected from among the codes. The central phenomenon is one that is extensively discussed by participants or of particular conceptual interest (Creswell & Poth, 2018). Two RAs, different from the RAs who coded the symptom themes, independently coded experiences of service use, paying particular attention to treatment barriers as the central phenomenon. The author met with the RAs to review and discuss the initial findings. As a

specific code emerged, the RAs critically assessed its validity by comparing it to descriptions of other experiences described by participants, until consensus was reached. A master code list was created and reviewed by the author for comprehensiveness and to compare the findings with group consensus.

During axial coding, the data are reviewed to provide insight into causal conditions that influence the central phenomenon, the strategies for addressing the phenomenon, the context and intervening conditions that shape the strategies, and the consequences of undertaking the strategies (Creswell & Poth, 2018). Information from this coding phase is then organized to represent a theoretical model of the process under study during selective coding, generating propositions that interrelate the codes in the coding paradigm. During the final stages of coding, the two RAs met and critically assessed codes, developing categories composed of codes that represented participants' treatment experiences. Once the main motivations emerged from the data, the author developed a theory, grounded in data, to explain the barriers and strategies to service use for ameliorating psychiatric distress.

Results

Traumatic Events and Community Violence Exposure

The mean level of discrete traumatic events reported on the TLEQ was 10.21 ($SD = 4.16$; range: 3–21). See Table 1 for a comparison of lifetime trauma exposure and trauma exposure during gang membership, based on TLEQ responses. The mean SECV-SF score, indicating participants' level of community violence exposure, was 96 ($SD = 32.62$; range: 13–61). Compared to several samples (i.e., patients in residential and outpatient substance abuse treatment, Vietnam War military veterans, undergraduate psychology students, and women in an intimate partner violence [IPV] support group) involved in the development of the TLEQ (Kubany et al., 2000), participants in the present study reported higher rates of the sudden and unexpected death of a loved one (90.6% vs. 88% of military veterans), having a loved one survive trauma (56.7% vs. 51% of IPV survivors), experiencing a life-threatening illness (34.4% vs. 30% of IPV survivors), being robbed with a weapon (75.0% vs. 36% of military veterans), witnessing an assault (90.6% vs. 69% of military veterans), being threatened with violence (87.4% vs. 82% of substance abuse patients and military veterans), and miscarriage (37.5% vs. 36% of IPV survivors).

Psychiatric Distress

Narrative Histories of Distress

Four participants (14.3%) reported no psychiatric distress. For example, Participant (P) 1034 reported, "presently, no. Presently, I'm good, you know. I mean, I, I'm dealing with life, you know." Other participants explicitly discussed depression (17.9%; $n = 5$; e.g., "I suffer from depression;" P1035), anxiety (10.7%; $n = 3$; "I don't want to ever be back there. I never wanna feel like that, you know, the depression and the anxiety and all that shit. I don't, no;" P1017), PTSD (14.3%; $n = 4$; "to a great extent I got that, what do you call that? uh, P-T, PTSD;" P1037), and substance abuse (53.6%; $n = 15$; e.g., "with, uh, the gang involvement came a lot of, uh, drug and alcohol use, and then it became excessive to the point where I was pretty much addicted;" P1042). In many cases, substance abuse represented avoidant coping. For example, Participant P1036 noted:

> I took on smoking cigarettes as a coping mechanism, um, drinking, um, drugs, um, anything that I could do to where I wouldn't have to think and deal with the fact I had murdered a man and that I was guilty of that murder no matter how I sliced it.

In fact, a thematic analysis revealed narratives of distress were predominated by traumatic stress and coalesced into superordinate themes of PTSD clusters (see Table 2). Overall, 89.3% ($n = 25$) of participants discussed experiencing at least one symptom of PTSD. A significant majority of participants (82.1%; $n = 23$) expressed experiencing symptoms related to alterations in arousal (e.g., "I was in a lot of violent institutions, and stress was, I was hype-, hypervigilance was an everyday factor. You were always hypervigilant of everything, and so much so that it, wear, it wears on the body;" P1042). Many participants (25%; $n = 7$) reported having intrusion symptoms (e.g., "I've had, um, you know, cold sweats or, like, nightmares while I'm sweating. I wake up sweating, and I'm having these nightmares of these, these violent things;" P1032). Approximately 25% of participants ($n = 7$) reported persistent avoidance in some form, mostly through substance use (e.g., "I didn't want to feel those things, so guess what I would do? I would get high. I would numb the pain. I would numb the trauma, in other words;" P1032). Negative alterations in cognitions and mood were also reported by a significant number of participants (32%; $n = 8$; e.g., "[the trauma] made me more, uh, hard, harder because I didn't ever want to be a victim;" P1035).

Further, about 28.6% ($n = 8$) of participants described associated features of traumatic stress, including protective posturing and desensitization. For example, Participant 1039 stated:

> I started getting recognized [for violence] … it just became very natural for me to…be the one that would inflict the violence… it stroked that shallow part of my ego to be recognized… But I chased it…using, like, leadership ability for very evil purposes

In other cases, participants described how trauma desensitized them to violence and lowered their empathy for others. Participant 1045 noted, "gunshots, you see people getting beat up, robbed all the time, uh, shootings, drive-byes. So, it, it does, it traumatizes you in the beginning, but then you kinda get, like, I don't know, used to all that.". Desensitization emerged in 25.0% ($n = 7$) of participant narratives. Given the contextual detail and gang-culture–informed perspective, the decreased empathy participants described appeared to be a coping

Table 1
Lifetime Trauma Exposure

	Lifetime exposure to discrete trauma		Trauma exposure during gang membership	
Trauma type	*n*	%	*n*	%
Natural disaster	23	71.9	13	40.6
Motor vehicle accident	13	40.7	7	53.8
Other accident that caused injury	8	25.0	7	87.5
Combat experience	6	20.7	4	66.7
Unexpected death of a loved one	29	90.6	22	78.6
Loved one survived traumatic event	17	56.7	14	73.7
Experienced life-threatening illness	11	34.4	6	54.5
Robbed with a weapon	24	75.0	22	91.7
Physical assault	27	82.1	24	88.9
Witnessed an assault	29	90.6	26	89.7
Threatened with injury	28	87.5	13	46.6
Childhood physical abuse	16	48.4	2	12.5
Witnessed family violence	19	55.2	3	15.8
Intimate partner violence	10	32.3	7	70.0
Childhood sexual assault by an elder	7	22.6	1	12.5
Childhood sexual assault by a peer	5	16.7	0	0.0
Adolescent sexual assault	4	12.5	4	50.0
Adult sexual assault	3	9.4	1	33.3
Unwanted sexual attention	5	15.6	2	40.0
Stalked	6	18.8	4	66.7
Miscarriage	12	37.5	6	50.0
Abortion	14	43.8	11	78.6
Other traumatic experience	18	56.3	14	77.8

Note. $N = 32$.

mechanism in response to chronic trauma exposure. Participant 1039 stated, "Um, [the traumas] made me very cold and callous. I would just shut things down…I just shoved everything down into this dark hole, and I did that for probably about 20 years of my life." In fact, one participant (i.e., P1035) described his insight into this process, saying:

> When I got into the criminal lifestyle it made me more calloused…you know, not really having empathy for other people because the fear factor of ever being a victim or ever going through that, or, uh, I guess, it's just kind of a defense mechanism that, uh, you know, the callousness of, uh, just, like, not caring about anybody else.

Current Levels of Distress

Table 3 documents self-reported distress and substance use. The PCL-5 scores of three participants who did not report PTSD symptoms qualitatively ranged from 0 to 9. There was a nonsignificant relation between the number of qualitatively reported PTSD symptoms and PCL-5 scores, $r = .25$, $p = .194$.

Table 2
Thematic Analysis Examining Histories of Distress

PTSD symptom theme	Quotation	Participant ID
Intrusions		
Trauma-related dreams	"I still have sleeping issues, um, there's nights that I wake up and just have nightmares or, um, been dreaming about things that have happened in the past and uh… so it's, I think sleeping is the worst part for me."	P1008
Physiological reactions	"when somebody reminds me of somebody, or reminds me of a certain look, I do get, you know, like, [my] body, um, start responding, um, or loud people, or especially males, they come and get me like, that vertical [look], I react to it, you know."	P1001
Persistent avoidance		
Internal experiences	"It was almost like I had to, um, I had to avoid thinking about it, you know, and, and then doing so, obviously when I went to prison, um, everything, I took on everything. So, that's the only way I knew how to deal with any type of stress and, you know, uh, emotional trauma, was to evade myself and just avoid it altogether, you know."	P1036
Negative alterations in cognitions and mood		
Negative beliefs	"Um, actually not, not like feeling, like worthy. Like, you know, like, I, I, shouldn't, you know, I shouldn't, say if I had, like, you know, even something small, like, I bought a new car. Like, man do I really deserve a new car because what I've seen or what I've done? Does that make sense?"	P1040
Negative emotions	"I did become, like, my, my heart became hardened. I wasn't feeling any emotion at all except for anger and hatred."	P1024
Detachment	"I even remember, like, my ex-girlfriends before would say, like, there was something wrong with me, there, there, there's, like, an emotional detachment."	P1039
Alterations in arousal and reactivity		
Aggression	"I ultimately just started taking all that unresolved stress, anger, and pain and started redirecting it on others by fighting and becoming violent with them."	P1034
Reckless behavior	"getting jumped, getting shot at, getting, I mean, guns at me, it's, like, I mean, now it's, like, isn't even a scary experience. Now it's a rush, you know? It's, like, I, it's, it's, it's the adrenaline of getting shot at, you know, that's, like, man, it's like, a high, you know what I'm saying?"	P1014
Hypervigilance	"I am very nervous, I am very scared at people watching me, people is trying to get me."	P1016
Concentration difficulties	"I had a hard time concentrating."	P1045
Difficulty sleeping	"Still there's times where, like, I can't sleep and stuff, you know what I mean? Because, like, I'm thinking about some of the things that I did."	P1026

Note. $N = 28$. PTSD = posttraumatic stress disorder.

Table 3
Current Levels of Psychiatric Distress

Variable	*M*	*SD*	%	Range
Depression (PHQ-9)	3.78	4.12		0–18
None			31.3	
Minimal			28.1	
Moderate			6.3	
Severe			3.1	
GAD total (GAD-7)	4.16	4.67		0–17
None			21.9	
Minimal			43.8	
Mild			25.0	
Severe			9.4	
Alcohol use (AUDIT)	4.56	6.16		0–23
Low risk			78.1	
Hazardous risk			12.5	
Harmful level			3.1	
Dependent level			6.1	
Drug use (DAST-10)	4.16	3.21		0–10
None			9.4	
Low use			34.4	
Moderate use			12.5	
Substantial use			28.1	
Severe use			12.5	
PTSD total (PCL-5)	14.50	15.24		0–69
Intrusions	3.75	4.28		0–19
Avoidance	1.84	2.34		0–8
NACM	4.59	5.53		0–23
Arousal	4.31	4.86		0–19
PTSD positive			12.5	

Note. $N = 32$. PHQ-9 = nine-item Patient Health Questionnaire; GAD = generalized anxiety disorder; GAD-7 = seven-item GAD scale; AUDIT = Alcohol Use Disorders Identification Test; DAST-10 = 10-item Drug Abuse Screening Test; PTSD = posttraumatic stress disorder; PCL-5 = PTSD Checklist for *DSM-5*; NACM = Negative Alterations in Cognitions and Mood subscale.

Treatment Experiences

Figure 1 outlines the grounded theory model of past to current psychiatric distress as a function of treatment experiences among this sample.

Treatment Barriers

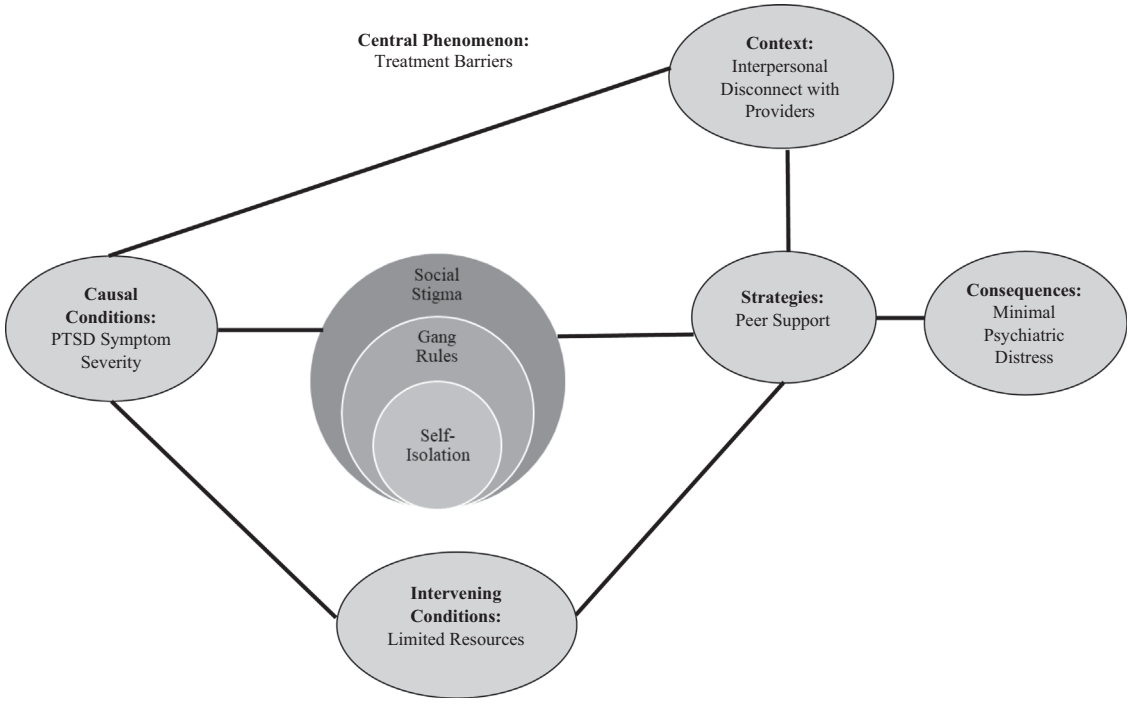
The central phenomenon of treatment experiences was treatment barriers that existed at the individual, community, and societal levels, defined by variations in social beliefs and rules discussed by 39.3% ($n = 11$) of participants. For example, Participant 1019 stated:

> I know that the, the spaces that I'm in, and the trauma, and the mental health, and those type of languages or conversations that are not, um, sexy in our community, or that are not, uh, had often, um, with the people that need it the most and it's not promoted in our community.

Individual-Level Treatment Barriers. At the individual level, 28.6% of participants described experiencing self-isolation wherein they believed their experiences of distress were unique to them (e.g., "I never thought that, uh, [there] was people in the world going through the same thing, that, this is how distorted my thinking was, I thought it was just me with all the problems;" P1013). In many cases, it appeared the self-isolation prevented participants from opening up to others (e.g., "I'm not comfortable talking about everything;" P1007).

Community-Level Treatment Barriers. Within the gang community, 10.7% of participants indicated that gang rules prohibited them from initiating treatment. This gang rule was, in some cases, explicit. For example, Participant 1011 noted, "Well, in the past, when I was part of the gang and in prison, [the gang] would not allow you to seek therapy." In other cases, there was an implicit awareness that seeking treatment would result in excommunication, at least, and likely victimization. Participant 1035 stated:

Figure 1
Grounded Theory Results Modeling Past to Current Psychiatric Distress as a Function of Treatment Experiences Among Former Gang Members



Note. PTSD = posttraumatic stress disorder.

> If you seek out mental health services, that's a sign of weakness, right? And usually you'll be victimized, or you'll just be excluded because you're a weak link. If you're weak enough to go ask for help, then you're too weak to be part of us.

Societal-Level Treatment Barriers. Some participants (17.9%) detailed the social stigma they faced with regard to experiencing mental health challenges. Participant P1011 noted,

> I come from a culture where it is very shame-based, you know, on my end. And, and, you know, we don't talk about anything, that, unless you're drunk, that's, you know, that's a soft place, and you know, we don't bring stuff out like that.

This social stigma appeared especially strong among this population given the immense pressure to keep up the appearance of stoicism (e.g., "there is stigma that is associated with [therapy]… it's like, 'ah man, you're a weenie, you're weak'…that could just open up a whole can of worms and people can start to treat you in a very bad way;" P1037), which was a survival tactic to reduce vulnerability to victimization (e.g., "if I did that [therapy], it would show a sign of weakness, and I never wanted anybody to even view me as being weak inside prison walls;" P1025).

Interpersonal Disconnect With Providers

When participants did seek treatment for their distress, there was an interpersonal disconnect with providers wherein some participants (25.0%) described beliefs that treatment providers would not understand their personal experiences. For example, Participant 1009 stated,

> Well, I mean, I tried, I tried seeing a counselor, and… a lot of them don't experience, or haven't experienced, what happened to me and what I've gone through. Um, it's, like, uh, if you've never walked in my shoes how, how can you help me? I guess I kinda speak that way. Like, people have a tendency of having a doctor's degree or psychiatry degree, but they've really actually never walked in my shoes or felt what I've felt. They can only say that we can kinda relate to what you're talking about, but they really can't.

Participants noted that in addition to the lack of similar experiences, cultural differences increased the interpersonal distance. Participant 1019 noted that "it wasn't people that looked like me. It wasn't people that shared the same experiences that I had. Um, it wasn't people that I could connect with that was leading those interventions."

Limited Resources

Further, some participants (14.3%) described having limited ability to access treatment. Participant 1039 described the difficulty he had trying to get into treatment options available in prison, noting:

> I was like very far down the list because, I guess, a lot of people, they can only put two people every 9 months. And, um, I was pretty persistent with the doctor because I saw her pretty often and then, um, I think it became more for me, like, ok, I wanna get in, I wanna get in so that every time I saw her I said, 'hey, is the group, have you started the new group yet?' She said, yeah she's about to, um, but I'm very far on the list so it might be a couple of years.

Another participant (i.e., P1034) described that he had limited resources to access treatment in his community outside of prison, noting:

> Currently, out here I haven't because it costs money, um it costs money actually to have a conversation with somebody. I mean… they'll talk to somebody about anything if, like, you gotta come out of your pocket to talk to somebody. So, uh, I guess the resources… aren't there.

Peer Support

Given the multilevel treatment barriers, in the context of interpersonal disconnect with providers and conditions related to limited resources, some participants (39.3%) sought out peer support services. These peer opportunities were both formal groups with a mission (e.g., "I became part of this group, and, um, we used to kind of, meet, you know… so it looked like a support group 'cause we was trying to see if there was, uh, other alternatives to the violence;" P1011), whereas others were informal support systems. For example, Participant 1037 noted:

> Now, I got, uh, like other lifers. Other guys that are in my situation. Um, we don't necessarily have a formal group, but there's, there's a few of us that are in the same situation, and… sometimes we get together for dinner, or sometimes we just kind of meet up at a park somewhere and kinda hang out. You know, we, we share a lot of the stressors, the, the problems that we are experiencing.

Discussion

The present study utilized a concurrent mixed-methods design to examine trauma exposure, narratives of distress, and current levels of psychiatric morbidity, as well as mental health treatment experiences among a sample of former gang members. Compared to several trauma samples, participants in the present study reported inordinate levels of trauma exposure on the TLEQ (Kubany et al., 2000). Trauma endorsement mostly increased during gang membership, which may be a function of participants' developmental period but is likely a function of gang life, especially in the case of violent victimizations. For example, more than half the sample experienced several different types of violence victimizations (i.e., robbed with a weapon, physically assaulted, witnessed an assault, stalked) during gang membership. Participants reported exposure to an average of five to six community violence events, with some reporting exposure to community violence that occurred monthly or weekly.

A thematic analysis was used to examine participants' narratives of distress in the context of *DSM-5* (APA, 2013) PTSD cluster symptoms. Most participants reported symptoms related to alterations in arousal, whereas around one-quarter of the sample reported symptoms of intrusion, avoidance, and negative alterations in cognitions and mood. However, it is important to note that participants were not formally assessed for PTSD during the interviews, and, therefore, the results do not accurately represent symptom prevalence. It is also important to note that traumatic stress symptoms described by participants are a natural reaction to trauma exposure; more research is needed to assess the frequency and duration of symptoms to determine a diagnosis of PTSD in this population.

In addition, participants described normalization and desensitization as coping responses to trauma, otherwise conceptualized as emotional numbing. Previous research has found that emotional numbing and aggression may occur at high levels of community violence exposure over time, whereas low levels of community violence exposure have been related to slight increases in anxiety and depression (Kennedy & Ceballo, 2016), indicating that individuals who are exposed to chronic community violence become accustomed to these events and suppress emotional symptoms, such as anxiety and depression, via avoidance coping strategies that may develop into aggressive tendencies as a means to respond to violent environments. Youth gang members have reported higher symptoms of emotional numbing compared to their non–gang-member peers involved in delinquent behavior (Kerig et al., 2016). More research is needed to assess associated features of traumatic stress among this population, including personality disorders. For example, assessment using a trauma- and culturally informed (i.e., gang culture) perspective can help tease apart differences between desensitization and callous disregard and avoid misdiagnosing cultural characteristics or traumatic reactions as personality disorders. It is possible the propensity for violent behavior exhibited by this population is indicative of a "code of the street" (Anderson, 1999) or protective posturing as opposed to an enduring personality characteristic.

The finding that these former gang members described symptoms of posttraumatic stress may not be surprising given research documenting trauma exposure to be among the highest factors for gang departure (Decker & Lauristen, 2002). It may be that individuals who leave their gangs are more vulnerable to psychiatric distress triggered by high rates of trauma exposure. It is interesting to note that current levels of distress (i.e., depression, anxiety, and PTSD symptoms) on self-report measures were minimal in the currents sample; one-eighth of the sample screened positive for PTSD. There was also a nonsignificant relation between symptom narratives and PCL-5 scores, which may reflect the fact that interviews did not formally assess PTSD, and many participants described previous reactions to traumatic events that were not current at the time of the interview. Average scores on the AUDIT and DAST-10 indicated low-risk and moderate alcohol and drug use, respectively. It may be that screening tools are not sensitive to detecting

psychiatric symptoms in gang-involved individuals (Beresford & Wood, 2016). For example, indoctrination of gang culture and norms may inhibit valid or reliable responses on these questionnaires, attenuating symptom reports. If current self-report symptoms are an accurate representation of symptom levels in this sample, minimal symptom reports may suggest resilience among these former gang members, as this is the modal response to adversity (Galatzer-Levy et al., 2018). For individuals with chronic or delayed trajectories, ongoing substance use may further emotionally numb traumatic stress; for those who have resolved or recovered from posttraumatic stress, it is important to understand the intervening factors to develop models of treatment for this population.

Grounded theory analysis revealed that participants were interested in treatment services for posttraumatic stress. However, participants were hesitant to seek services due to social isolation, gang rules, and social stigma. Even after overcoming these treatment barriers, participants' access to services was limited by financial and availability resources. When they accessed treatment, participants experienced an interpersonal disconnect with providers. In response to these varied obstacles, participants reported utilizing informal and formal peer support services, which may have decreased posttraumatic distress to currently low rates. A meta-analysis evaluating 27 qualitative and mixed-methods studies of peer support in adult mental health services found peer support workers to be viewed as role models, easily build rapport with those in recovery, and destigmatize mental health challenges; consumers working with peer support workers reported experiencing increased hope, motivation, and social networks (Walker & Bryant, 2013). Thus, peer support in the lives of gang-involved individuals may play a differential role, depending on the antisocial or prosocial aspects of peers: Just as peers may reinforce risky behaviors, prosocial peers may buffer the relation between violence exposure and internalizing symptoms (Rosario et al., 2008). Homeboy Industries is an exemplary community organization that capitalizes on prosocial peer support in trauma recovery for at-risk youth and former gang members by providing opportunities to develop prosocial identities through employment, education, and training as well as by providing trauma-informed and peer-run clinical support services (Leap et al., 2011).

In light of the finding that former gang members reported high rates of violent victimization during gang membership and experienced posttraumatic sequelae consistent with PTSD, there is a need for health and/or justice systems that interface with gang-involved individuals to utilize a trauma-informed approach and attend to a wider range of posttraumatic symptoms in engagement, treatment, and rehabilitation efforts. Specialized training on the intersection of gang culture and trauma exposure for personnel who serve gang-involved individuals (e.g., Dierkhising & Kerig, 2018) may decrease interpersonal disconnect. In addition, mental health consumer and community programs that increase awareness about mental health challenges and treatment services may decrease stigma (e.g., Corrigan, 2015), especially among ethnic minorities, if diverse cultural understandings of mental health are included (Knifton et al., 2009), and facilitate trauma recovery for involved individuals (Fields et al., 2020). Relatedly, access to evidence-based treatments for PTSD (Watkins et al., 2018) should be prioritized, and research will be needed to evaluate the effectiveness of these interventions in this population. Given that individuals usually join gangs during adolescence, it is particularly important for intervention efforts to focus on youth, as early identification and appropriate treatment may help prevent the development of chronic posttraumatic stress and intervene in the cycle of violence.

The criminal justice system may be the first intervention opportunity for gang-involved individuals. As such, therapeutic interventions being developed with justice-involved U.S. military veterans, another "niche population with unique needs" (Russell, 2009, p. 363), may serve as a promising treatment model. Veteran treatment courts are problem-solving courts that provide access to treatment and motivation for engagement among justice-involved veterans. It may be beneficial to review such models (e.g., Blue et al., 2013) in conceptualizing how to meet the needs of therapeutic justice for gang-involved individuals. In systems that may be overburdened and underresourced, peer support services have the potential to engage this marginalized population by destigmatizing the experience of traumatic stress and decreasing isolation through engagement with peers who have a unique insight into shared experiences (MacLellan et al., 2015). In a systematic review of 11 randomized controlled trials comparing peer support consumers to individuals working with mental health professionals, no significant differences were found among the 2,796 included participants (i.e., adults diagnosed with a mental health condition) with regard to symptoms, hospital admissions, mental health service use, psychosocial functioning, quality of life, social relations, or client satisfaction (Pitt et al., 2013). However, there was a small reduction in crisis and emergency service use among peer support consumers (Pitt et al., 2013). Thus, peer support services offer a noninferior alternative to inaccessible medical treatment models.

The present study benefited from the use of mixed-methods procedures that illuminated contextual insights into psychological responses to traumatic experiences and captured the discordant experiences of past and present mental health, including varying social processes implicated in the trajectory of posttraumatic stress symptom resolution. Another strength of this study was the recruitment of a hard-to-reach population, with participants who reported dense lived experiences and were or had been deeply submerged in gang life. However, the sample size was small and comprised mostly of men, and, to increase anonymity, specific gang affiliations were not assessed. Given the recruitment methods, participants may have had a positively biased view of peer support services. In addition, retrospective analysis precluded the ability to attribute posttraumatic stress symptoms to gang life, as many of these former gang members experienced adverse childhood experiences, which may have initially triggered traumatic stress and motivated gang

membership. Impairment and dysfunction related to posttraumatic stress were also not assessed, which is an important issue to consider. Participants current levels of distress indicated that most did not meet the criteria for a PTSD diagnosis; participants in this sample may have been further along in their recovery process, as the average time since gang membership was approximately 12 years, or they may have represented a highly adjusted and resilient sample. Further, an examination of the differences between individuals who received peer support and those who did not was beyond the scope of this study, but further research into this area could inform the development of peer support services for this population.

Relatedly, participant involvement in peer support, social services, and/or formal psychotherapy may have influenced their narratives of gang life. Thus, this sample may not be representative of all former or current gang members who have not experienced posttraumatic stress, do not have an interest in treatment, and/or have not benefitted from peer support. Future research with gang-involved individuals, generally, can assess PTSD using gold-standard measures (e.g., Clinician-Administered PTSD Scale for *DSM-5*; Weathers et al., 2013a) to evaluate the prevalence of PTSD as a function of gang-affiliated centrality. Future research with former gang members, specifically, may benefit from (a) examining peer support structures and processes to develop and enhance acceptable and feasible treatment programs; (b) evaluating the effectiveness of peer support services to verify and maximize the benefits; and (c) assessing the contribution of a trauma-informed perspective to the development of models of care and rehabilitation.

Open Practices Statement

The study reported in this article was not formally preregistered. Neither the data nor the materials have been made available on a permanent third-party archive; requests for the data or materials should be sent via email to the author at chvaldez@csumb.edu .

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