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Social workers' perceptions on community violence and resilience : the impact of assessment and treatment when working with children and adolescents

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and Adolescents

ABSTRACT

This mixed methods, primarily qualitative study examined social workers'

perceptions about community violence and resilience. Additionally, this research

examined how perceptions influence the assessment and treatment that social workers

provide their clients. The study included 25 participants who responded to an online

survey, which included questions addressing participants' demographics, as well as their

conceptualization of resilience, community violence, and how they practice. Most of the

participants were female (24 of 25) and 1 was male. The majority of participants were

from the Boston area or the San Francisco/Oakland area. The participants worked in a

range of settings, including schools, hospitals, and community based agencies. This

study addressed the following research question: Is there a gap between research and

practice in regards to perceptions of resilience for children exposed to community

violence?

SOCIAL WORKERS' PERCEPTIONS ON COMMUNITY VIOLENCE AND

RESILIENCE: THE IMPACT OF ASSESSMENT AND TREATMENT WHEN

WORKING WITH CHILDREN AND ADOLESCENTS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2009

ACKNOWLEDGMENTS

This thesis is dedicated first and foremost to my parents, for their patience and guidance, and for instilling within me an interest in working toward creating a more just and peaceful world.

I would also like to express my appreciation to Shella Dennery for her guidance and support during this difficult process. I am certain that this final product would not have been possible without the teaching, guidance, and friendship that you provided.

Thank you to the teachers and staff at Smith who have touched my life over the past three summers. You have pushed me far beyond what I had previously thought possible of myself and inspired an immeasurable amount of growth.

I would like to acknowledge the rest of my cohort at Smith for keeping sure that the light at the end of the tunnel never faded away, and for continuously making me a better person. I am forever indebted to you all who I now call friends, and will soon be honored to call colleagues as well.

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CHAPTER 1

INTRODUCTION

Community violence is an omnipresent force within this society, and its effect is felt disproportionately based upon socioeconomic status and ethnicity. The United States has the highest rate of childhood homicide, suicide, and fire-arm related death of any industrialized country in the world (National Center for Children Exposed to Violence, 2008).

While being the victim of a violent act is extremely traumatic, witnessing or hearing about violence happening in one's community can also have an intensely damaging impact. In inner city neighborhoods, roughly one-third of teenagers have been victims of community violence, while nearly all have been exposed to violence (Margolin & Gordis, 2000). Margolin & Gordis (2000) define exposure as witnessing a murder, assault, robbery, or drug use but many researchers broaden their scope, taking into account the detrimental impact upon those who hear about a violent act in their community. Exposure to community violence, whether through direct victimization or witnessing, has been found to result in anxiety, depression, and post-traumatic stress disorder in the short term. Over time, chronic exposure can alter the child's progression in their developmental tasks. In past research, there have been elements, called protective factors, which have been found to mediate this detrimental impact. Previous studies have found that religious involvement, and spirituality, as well as formal and informal social supports have mediated the detrimental affects of community violence on children (Jones, 2007; Bradley, Schwartz, & Kaslow, 2005). Due to this knowledge, this study set out to determine social workers' perceptions about community violence and resilience.

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Additionally, it examined how these perceptions impact the way that social workers assess and provide treatment around issues of community violence exposure.

The high prevalence of violence in urban communities makes it extremely important to look at protective factors which can help to mediate the impact. In addition, it is necessary to look at the way social workers perceive protective factors and resilience in children exposed to community violence. Beliefs about resilience held by social workers likely influence their practice in many ways. For instance, it is likely that decisions to screen or not screen for community violence exposure are based upon perceptions that social workers hold. Additionally, it is possible that social workers develop a tolerance or acceptance of the violence in urban areas, also impacting the work that they do. The way in which social workers will address and treat community violence exposure may be based upon their perceptions of resilience. This study explored this connection.

This qualitative study examined how social workers perceive community violence and resilience in children and adolescents exposed to community violence. The study also looked at how social workers assess and treat their clients who have had experiences with community violence. Some research on community violence and resilience currently exists, however the research has not explored the social work perspective. It is hoped that this research will be read by current and future social workers who will realize the importance of community violence screening and treatment. Additionally, this research intends to highlight that although community violence exposure can be extremely harmful, that it can be mediated by a variety of factors which

social workers must consider in order to fully embrace a strength based approach in their

work with children and adolescents.

CHAPTER II

LITERATURE REVIEW

This chapter will be divided into three main sections. The chapter will begin by

reviewing the research and literature on community violence. This section will also

explore the potential impact that community violence exposure can have upon children

and adolescents. Next, the factors that have been associated with risk and resilience will

be outlined. Lastly, the chapter concludes with a discussion on how community violence

is assessed and how it is treated in practice settings.

Community Violence and Potential Impacts

Community Violence

This section will define community violence, explore the impact on children and

adolescents, and discuss diagnosis. Community violence is an important public health

concern. In 2003, an average of 15 young people between the ages of 10 and 24 were

killed each day in the United States (Centers for Disease Control, 2008). Of the 5,570

young people who were murdered that year, a firearm was used in 82% of the cases

(Centers for Disease Control, 2008). The 2002 National Youth Survey conducted by the

Center for Disease Control and Prevention found that of the 1,725 adolescents surveyed,

nearly 70% had been victims of at least one violent crime during their adolescence

(Aisenberg & Herrenkohl, 2008). Given the extremely high rate at which children are

direct victims of violence, one can begin to comprehend how frequently children witness

and hear of acts of violence in their communities.

Community violence takes the lives of thousands of Americans each year. However the psychological impact upon its victims, witnesses, and those who inhabit the neighborhoods is often forgotten. Berman, Kurtines, Silverman, and Serafini (1996) found that in an inner-city sample of low-income African American youth living in Miami, 43% of participants had witnessed murder. When other types of violent crime such as stabbing, murder, shooting, and mugging were considered, the percent who had witnessed such events jumped to nearly 87% (Berman, Kurtines, Silverman, & Serafini, 1996).

Community violence will be defined for this study as violence between two or more individuals who are not biologically related to one another, occurring independent of the home environment (Voisin, 2007). Exposure to community violence could include, but is not limited to: hearing about, witnessing, or being directly involved in murder, assault, or robbery.

Impact of Witnessing Community Violence

Exposure to community violence can lead to a variety of internalizing and externalizing problems for children and adolescents. According to Barbarin, Richter, and deWet (2001), exposure to violence (either direct or witnessed) has been shown to result in numerous symptoms such as "loneliness and sadness, loss of desire for amusement, daydreaming, inattention, disrupted sleep, nightmares, easy perturbation, intrusive disturbing imagery, separation anxiety, and fear of death" (p. 16). Internalizing problems such as depression and anxiety, as well as post-traumatic stress disorder symptoms are prevalent in those exposed to community violence (Luthar, 2006; Lynch, 2003; Voisin, 2007), which is likely a response to a lost sense of safety. In other words, experiences of

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community violence destroy a child's inherent belief that their neighborhood is a safe place (Voisin, 2007). What was once experienced as a relaxing and carefree walk down the street can easily become a threatening experience that invokes a heightened state of arousal. Tied to hypervigilance is anxiety, much of which has been found to revolve around feelings of potential danger. Cooley-Quille, Boyd, Frantz and Walsh (2001) found that high levels of community violence exposure resulted in "fears of injury, the unknown, and danger" (p. 203), further evidence that community violence threatens ones feeling of personal security.

The hypervigilance that results from the experience of community violence can translate into a variety of externalizing problems. Increases in juvenile justice involvement, antisocial behaviors, and delinquent acts are all associated with exposure to community violence (Gorman-Smith & Tolan, 1998; Voisin, 2007). This hypervigilance displayed by children exposed to chronic community violence, although adaptive while in the community, may prove to be maladaptive in other situations (Garbarino, Kostelny, & Dubrow, 1991). For instance, hypervigilance at school may result in an accident (such as being bumped into) being perceived as a threat, which is then met with a response that is actually unwarranted by the situation itself (such as assaulting the other child).

Internalizing and externalizing problems that have been associated with community violence exposure can impact school functioning as well. Schwartz and Gorman (2003) studied 237 elementary school students, utilizing self-reports of community violence exposure. These reports, as well as student's GPA scores and achievement test scores were then analyzed. In this study, a greater amount of community violence exposure was associated with lower test scores and lower GPA's.

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This study further outlines the unfavorable impact that community violence exposure can have upon children. The researchers in this study suggest that "functioning at school (may be) hindered by symptoms of depression" as well as "aggression and hyperactivity" (Schwartz & Gorman, 2003, p. 171).

Although there is still much to learn about the type of traumatization experienced by those who witness violent acts, past research has found that "exposure to vicarious violence produces effects parallel to those observed when the violence involves direct victimization" (Barbarin, Richter, deWet, 2001, p. 23). In fact, research by Richters and Martinez (1993) found only a .02 difference in correlation between those who had been victimized and those who had witnessed a violent act when measuring for the child's level of distress. Research such as this clearly shows that witnessing the committing of violence can be extremely detrimental to the psyche of children and adolescents, producing a similar impact as would be seen had the individual been victimized themselves.

In addition to the aforementioned externalizing and internalizing problems, it is likely that children who are raised in violent communities will experience increased aggressive impulses (Gorman-Smith & Tolan, 1998). Much in the way children who participated in the famous study of social learning conducted by Bandura, Ross, and Ross (1961) were more likely to be violent after witnessing aggressive behavior, children who experience a childhood exposed to community violence are at a much greater risk for aggressive impulses and violent behavior themselves. Bandura (1961) concluded that children in the experiment were not likely to be violent inherently without witnessing violent behavior. Subsequently, it is logical to say that children who are raised in

communities' void of chronic violence are much less likely to be at risk for violent behavior. To claim that all children exposed to chronic community violence will act in a violent manner would be preposterous. However, research shows that the risk of aggressive impulses certainly increases in relation to the degree of violence exposure (Gorman-Smith & Tolan, 1998).

As shown by these previous studies, exposure to violence can have a detrimental impact upon children and adolescents. A number of behavioral and psychological issues can be created after exposure to even an isolated incident. Based upon this information, what then is the impact of multiple or chronic traumas?

Recurring Trauma: Complex PTSD and Developmental Trauma Disorder

According to the DSM-IV-TR (1994) a diagnosis of post-traumatic stress disorder is applicable after exposure to a potentially traumatic "event". Recently, many have begun the formulation of alternate diagnoses that may better encompass the experiences of children and adolescents exposed to community violence. The pervasive and chronic nature of community violence exposure has lead to the formulation of these two main alternate diagnoses: Complex post-traumatic stress disorder and developmental trauma disorder. Although neither of these diagnoses are included in the most recent version of the DSM-IV (1994) due to their relative youth of existence, both diagnoses remind clinicians that chronic trauma differs from isolated traumatic events.

Complex post-traumatic stress disorder (or C-PTSD), a concept initially proposed by Judith Herman (1992) in her book *Trauma and Recovery*, seeks differentiation for those exposed to prolonged, repeated trauma. Herman argues that the current diagnostic criteria for post-traumatic stress disorder, are limited to describing specific traumatic

events such as rape or military combat exposure. A more specific, and specialized

diagnosis such as C-PTSD could help clinicians to determine the impact that prolonged

trauma, specifically community violence, has upon children and adolescents.

Much in the same vein as C-PTSD, is the proposed diagnosis of developmental

trauma disorder (DTD). DTD suggests that while individual traumatic events produce

"discrete conditioned behavioral and biological responses", chronic traumatization

actually has "pervasive effects on the development of the mind and brain" (van der Kolk,

2005, p. 3). Based on this diagnosis, exposure to community violence is a detriment to a

child's entire developmental trajectory, rather than just an isolated segment of

functioning.

Both, complex post-traumatic stress disorder and developmental trauma disorder

encourage clinicians to look at children and adolescents exposed to community violence

(or any chronic trauma) more thoroughly, as they argue for a dichotomy between isolated

trauma and chronic trauma. It is important to remember however, that both of these

concepts are not completely understood yet, with both emerging out of the perceived

incomplete and inadequate nature of using traditional PTSD diagnostic criteria with

children and adolescents exposed to chronic trauma.

Protective and Risk Factors

The following section will focus on internal and external resources that can

influence the way in which individuals respond to and react to community violence. This

section has four sub-sections: resilience, social support, spirituality, and attachment.

Resilience

When working with those impacted by community violence, it is important to take a strength-based approach and consider the ways in which many of its victims, both direct and indirect, are able to overcome its deleterious effects. Prior to the outset of resilience literature in the 1960's, psychological research was symptom-based. In other words, therapists looked at the elements of a person that were functioning improperly. Resilience literature began to notice "positive adaptation… in life circumstances that usually lead to maladjustment" (Luthar, 2000, p. 742). Early resilience literature spent much of its focus looking at individual characteristics or traits which helped to buffer the impact of a stressor (Aisenberg & Herrenkohl, 2008). This approach was problematic because individual traits are fixed, rather than static, and tell social workers little about ways in which they can help their clients. More recent research has found a variety of elements which help to mediate the detrimental impact that community violence exposure has shown to have upon children and adolescents. Literature often refers to these elements as "protective factors" or "moderating factors." In past research, social support, religiosity/spirituality, and a secure attachment style have been found to be most helpful in promoting resilience when facing adversity or after a potentially traumatic event. Although resilience is a word recognized by most, its definition is not necessarily static. For the purpose of this research, resilience is defined as "positive adaptation despite experiences of significant adversity or trauma" (Luthar, 2006, p. 742). In other words, resilience is a term concerned with what it is about people that allows them to maintain a normative level of functioning, despite experiences which have proven to be problematic for many others.

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Social Support

This section will define social support and review numerous studies that have shown that support can buffer the impact and effects of community violence. Social support is defined as "the degree to which an individual believes support is generally available from the array of people in her or his social network" (Sheets and Mohr, 2009, p. 152). This social network can include family, friends, and other important members of a child's life such as teachers or coaches. It is also important to note that this definition stresses the importance of perceived social support rather than just the existence of individuals who may or may not be providing support. Much of the past research on social support has focused specifically on support being provided by parents or primary caregivers. This viewpoint is countered by studies which use a wider definition, adding that non-blood relatives, friends, and teachers can also be sources of social support. For the purpose of this literature review, studies with both ideologies are included.

Kliewer, Lepore, Oskin, and Johnson (1998) examined the psychological well-being of 99 children between the ages of eight and twelve who had experienced community violence exposure. Their study found that the detrimental impact of community violence exposure was most considerable when the children had low levels of perceived social support. The researchers looked at the frequency of internalizing symptoms present in order to determine the degree of impact that the community violence exposure had. In this study, social support was measured by assessing the child's perceived feelings of support by their primary caregiver. It is important to note however, that this method of operationalizing social support may be incomplete or miss support that a child is receiving through alternate relationships in their life.

The findings of Kliewer, Lepore, Oskin, and Johnson (1998) were supported in the research of Brookmeyer, Henrich, and Schwab-Stone (2005). This research also operationalized social support as coming from a parent, choosing not to look at relationships with other adults or peers. The study, which utilized 1,599 middle school students in an urban community, sought to determine if parental support could mediate the link between witnessing community violence and committing violent acts. Findings of this study differed across gender, finding that the association between witnessing and committing violence was strongest among males who reported low levels of parental support. The findings of this study offer slightly more detail than past studies in that this study found that even "average" levels of parent support were enough to curb the detrimental impact of witnessing community violence. Despite the additional details that this research provides, a negative correlation still exists between social support (in this case, parental support) and the negative impact of community violence exposure.

Counter to the two previously mentioned studies, Jones (2007) utilized a view of social support that encompasses the influence that other significant people can have upon children and adolescents. Jones (2007) studied 71 African American children between the ages of 9 and 11 who lived in the highest crime and poverty area of Houston, Texas. The study looked at how formal and informal kinship interact with experiences of chronic community violence in children's development of complex post-traumatic stress disorder (C-PTSD). The results of the study found that kinship support was negatively correlated with C-PTSD. Kinship support was measured both formally and informally. Formal kinship support referred to the "connections… maintained through patterns of contact that are proximal, frequent, and consistent (within) the nuclear family" (Jones, 2007, p.

130). Informal kinship support is a result of a "collective social identity whereby one has a view of oneself as part of a community" (Jones, 2007, p. 130). This collective view stresses the importance of informal kin, who are not actually blood relatives, yet are treated as though they are and they often "acquire family-like titles" (Jones, 2007, p. 130).

Hammack, Richards, Luo, Edlynn, and Roy (2004) studied 196 African American sixth grade students attending public school in inner-city Chicago. In this study, social support was conceptualized as "perception of the availability of interpersonal relationships reflected" (p. 451) in the everyday lives of the children. Due to the difficulty in measuring such a complex concept, Hammack et al. (2004) used a range of assessment tools to measure overall social support for each participant. The researchers looked at internalizing symptoms such as anxiety and depression and found that social support, as measured by the Survey of Children's Social Support Scale, mediated the presence of internalizing symptoms displayed by children who had been exposed to community violence. This research is consistent with previous research which has shown the potential that social support has to buffer against the potentially deleterious impact of community violence exposure.

Haden and Scarpa (2008) examined how community violence victimization impacted the prevalence of depression in young adults. Five hundred and fifty college students participated in the study, filling out questionnaires that measured perceived social support, current depressed mood, and their experiences with community violence victimization thus far in their lives. The study found that the impact of community violence victimization was most significant when participants exhibited low levels of

perceived social support. This study operationalized social support as perceived support from family and friends. The findings of this study are consistent with previous research which has found perceived social support helps to mediate potentially traumatic life events (Bradley, Schwartz & Kaslow, 2005; Keppel-Benson & Ollendick, 1993).

Research by Ozer and Weinstein (2004) found that support from "specific individuals" had a protective effect for children and adolescents exposed to violence. The study's participants were 349 middle school students in an urban area of California. This study, rather than looking at a specific relationship to measure social support, examined the participant's relationships in five major catagories (mother, father, sibling, friend, and teacher). Results of the study showed a negative correlation between parental support and PTSD symptoms in regards to support from both mothers and fathers. A similar pattern was found for siblings, but was less significant for support received from teachers. This presumably is because of the reduced frequency of time that children spend with teachers versus family. The findings of this study confirm the power that social support can have to protect or buffer the detrimental impact that violence exposure can have upon children and adolescents.

Barbarin, Richter, and deWet (2001) conducted a longitudinal study of 625 black children in South Africa. They were interested in the factors which promoted resilience for these children who had been exposed to political, family, and community violence. The researchers found that community violence correlated most significantly with adverse outcomes. Despite this finding, they determined that family and social relationships (social support) moderated these adverse outcomes. This is noteworthy, as it mirrors much of the current literature that speaks to the power of social support and

relationships in regards to buffering the potentially negative impact that trauma exposure can have upon children and adolescents.

As demonstrated by the included research, social support can buffer the detrimental impact of community violence exposure and trauma. Although the way in which social support was measured differed between the studies, the positive impact that it can have was consistent. This further supports the need to study how social support and resilience are understood and incorporated into treatment for those who have been impacted by community violence.

Religiosity/Spirituality

This section introduces studies that have found religiosity and/or spirituality to be correlated with resilience in children who have experienced adverse or traumatic events in their lives. This section examines both religion and spirituality because this encompasses a wider view of a belief in a higher power.

Jones (2007) studied 71 African American children between the ages of 9 and 11 who lived in the highest crime and poverty area of Houston, Texas. The study looked at how spirituality interacts with experiences of chronic community violence in children's development of complex post-traumatic stress disorder (C-PTSD). The study found that children who reported "low spirituality (and) increases in exposure to community violence (experienced) increases in C-PTSD" (Jones, 2007, p. 140). In other words, for children who did not identify as spiritual, the exposure to chronic community violence was more likely to result in the formation of complex PTSD.

Lawson and Thomas (2007) also discovered the compensatory effect of spirituality in their study of survivors of Hurricane Katrina. Their study of ten older

Black men and women who were forced to migrate after the Hurricane found that reliance on a higher power increased the ability to cope with this disaster. Participants spirituality was usually informal, and manifested through talking to a supernatural force, prayer, reading of religious materials, and helping others in coping with Katrina. According to the participants, their action in helping other survivors is rooted in their "religious beliefs" (p. 348). One participant identified that this helped her because it distracted her from her own troubles. This study helps to understand how religiosity and spirituality can promote resilience after one has experienced adversity or trauma.

Attachment

Attachment is a psychological concept that aims to explore and explain the nature of human relationships. Its premise is that early relationships in life create a mold or archetype that influences all future interactions and relations. Attachment is understood in terms of types (or styles) that include secure, avoidant, ambivalent, and disorganized. This section discusses past research which has found a correlation between a secure attachment style and resilience.

Past literature has shown that attachment promotes resilience by acting as a protective factor after the exposure to violence. For instance, Engle, Castle, and Menon (1996) discussed the significance of a "stable emotional relationship" (p. 631) in the context of buffering the impact of violence exposure. Luthar's (2006) review of past literature discussed the important role that secure attachment can have in the context of the exposure to violence. Luthar (2006) writes that attachment early in life "places people on probabilistic trajectories" (p. 756). These trajectories result in either healthy or unhealthy coping to stressful events, and shape the way in which people interact for the

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remainder of their lives. In the context of community violence and adversity, it becomes easy to see how a secure attachment style improves an individual's chance of resilience. Luthar (2006) suggests that a secure early attachment promotes healthier and more beneficial relationships later in life, making the individual more acceptant of nurturance, which in turn creates better outcomes in stressful or adverse situations. The research of Conger, Cui, Bryant, and Elder (2000) support this concept. Their longitudinal study examined a group of seventh graders to determine the parent-child relationship patterns within their family. Participants were then looked at eight years later in early adulthood, to examine their current romantic relationship, if they were in one. The study found that the relationship of the parent and child was the best predictor of later romantic development, measured by self-reported relationship quality.

In addition to violence exposure mediation, research has shown that a secure attachment can promote resilience in a variety of populations. Research by Van Der Zee, Ali, and Haaksma (2007) looked at the role that attachment plays for children who are coping with cultural transition. The study included 104 expatriate children between the ages of 8 and 18. The study sought to understand factors that promote successful coping with the transition to a new country and culture. The study looked at a variety of different cultural transitions, with children from 21 different home countries now residing in 37 different countries. The duration that participants had been living in their host country varied, with the range being between 6 months and 15 years. The research found that attachment style was the strongest predictor of successful adjustment. The research also found that an ambivalent attachment style was negatively correlated with quality of life as well as adjustment. This indicates the strong power that attachment style has at

predicting resilience in situations of adversity. Although the experience of moving to a new country is not the same as experiencing community violence, this study displays that a secure attachment style can promote resilience in situations which are stressful or difficult.

The work of Zakin, Solomon, and Neria (2002) also found attachment style was directly related to resilience. They studied the relationship between attachment style and the development of post-traumatic stress disorder (PTSD) in Israeli Prisoners of War (POWs) and combat veterans from the 1973 Yom Kippur war. The study included 164 former POWs as well as 189 combat veterans, all of whom were male. The study found that attachment style alleviates the potentially negative impact of trauma and stress. The PTSD symptoms that were associated with combat and the captivity of being a Prisoner of War were lessened in soldiers who exhibited a secure attachment style.

Ditzen, Schmidt, Strauss, Nater, Ehlert, and Heinrichs (2008) looked at the role that attachment plays in relation to responses to stressful situations. The study included 63 men who were either in cohabitating relationships or married and were between the ages of 20 and 31. It was required that the men had been married or living together for at least three months prior to entering the study. The study instructed the men's partners in the experimental group to provide social support while men in the control group were secluded prior to the stressful event. The men were then administered the Trier Social Stress Test, which includes a five minute job interview as well as a mathematical task which is performed in front of two strangers who evaluate the participant. The researchers hypothesized that men with a secure attachment style would benefit from social support at a greater rate than men who did not have a secure attachment style.

Results of the study supported the hypothesis, finding that men with a secure attachment benefited from social support more than those with other attachment styles. In other words, attachment style and social support interacted to buffer the impact of anxiety during a stressful experience.

Bartley, Head, and Stansfeld (2007) looked to determine if attachment style was related to resilience in terms of employment. The study sought to see if the attachment style buffers the occupational achievement of people with less educational attainment. The study looked at 10,308 civil servants in England over a period of 14 years, with 6,895 of the participants being males and 3,413 being females. Interestingly, the study found that participants who had attained high levels of education were likely to have occupations in the higher levels of civil service regardless of attachment style. However, participants who did not have high levels of education were more than twice as likely to occupy higher levels of civil service if they had a secure attachment. This research further supports the ability of a secure attachment style to promote resilience in the face of adversity.

As this section has shown, a secure attachment style can help to alleviate the potentially negative impact of traumatic or adverse situations. This is relevant to this thesis project because it helps to inform clinicians about ways in which they possibly can accommodate their treatment specifically for those who have been impacted by community violence.

Assessment and Practice

As seen from previous research, there is a great deal of information on the impact that community violence exposure can have upon children and adolescents. Additionally,

a number of factors which can buffer this impact have been identified through numerous studies. Despite this knowledge, past research has shown that social workers fail to fully address issues of community violence when working with children and adolescents (Voisin, 2007). This is a vital misstep when working with children and adolescents, especially in urban communities where the prevalence of community violence is so great. Failing to assess for client's experiences with community violence may result in only a partial understanding of the client's psychosocial stressors.

Research by Guterman and Cameron (1999) found that therapists reported significantly less community violence experience for their clients than the clients themselves did. The study utilized 67 children and adolescents (ages 9 to 19) in a residential treatment facility. The discrepancy between client reports and therapist's knowledge in regards to community violence exposure is even more informative because therapists reported levels of domestic abuse and sexual abuse at nearly the exact same level as clients themselves reported. The largest gap between client's experiences and therapist's knowledge existed in regards to the amount of witnessed violence. For this topic, therapists reported significantly lower amounts for all eight items within the category. Studies such as this raise questions about why such a large gap exists between client's experiences and their therapist's knowledge. One possible explanation is that therapists have no "legal obligation" (Guterman and Cameron, 1999, p. 388) to report community violence as they do with violence within the home or sexual abuse. For this reason, therapists are less likely to assess for client's experiences with community violence. Even if an intake form asks a question about community violence exposure,

any acknowledged experience by a client is likely to fall to the wayside if they also report domestic violence or assault (sexual or physical).

Assessing for community violence exposure becomes even more critical when one understands how easily PTSD symptoms can be mistaken for hyperactivity or conduct disorder (Aisenberg and Mennen, 2000). In many cases, the danger exists for educators and even more skilled therapists to incorrectly recognize these diagnoses in the children with whom they are working. These types of diagnoses attribute the child's behavior to the individual, rather than the environment in which they are living. As stated previously, these environments which are laden with violence can have catastrophic impacts upon the children and adolescents who are developing within them. Aisenberg and Mennen (2000) describe it as "crucial to rule out PTSD as a cause for deteriorating school performance, poor concentration, irritability, or aggression" (p. 349) before diagnosing a child or adolescent. While it is unclear how often PTSD is considered during the process of diagnosis, neglecting to do so clearly may result in improper diagnosis and treatment implementation.

There is a surprising dearth of literature that examines if and how therapists assess their clients for exposure to community violence. Additionally, little is known about the way that treatment is implemented when therapists are aware of their client's community violence experiences. It is important that further research examines the topics of assessment and treatment in order for clinicians to learn more about the way in which they practice. Voisin (2007) argues that clinicians who work with those exposed to community violence should be "systematically trained how to use standardized violence exposure measures" during their assessment of "at-risk youth" (p. 59).

Summary

As this chapter demonstrates, community violence is extremely prevalent and can have a detrimental impact on the functioning of children and adolescents. This detrimental impact can be moderated by a variety of factors such as social support, religiosity or spirituality, or a secure attachment style. Despite this knowledge, the screening and assessment of community violence exposure falls far short in most cases. Social workers must improve their efforts in order to better understand their client's life experiences. As this important step has not yet been taken, this exploratory study aims to determine how social workers' perceptions of community violence and resilience influence their assessment and intervention with children and adolescents who have potentially been exposed to community violence.

CHAPTER III

METHODOLOGY

This study explored social workers' perceptions of community violence and resilience in children and adolescents. The research questions guiding this study were: 1) Are social workers' perceptions of protective factors congruent with past research? 2) How do social workers' perceptions of protective factors influence the treatment they provide to their clients? This exploratory study was without a hypothesis, as research of this nature simply aims to gather information on a topic for which little or no previous research has been conducted.

This qualitative study was conducted utilizing fixed methods in the form of 14 short-answer questions and 7 demographics questions (Appendix D). Fixed methods research uses a set series of questions which are consistent for each participant in the study (Anastas, 1999). Unlike a flexible methods design which allows researchers to include additional questioning as it arises, fixed methods research does not allow for new follow up questions based upon participants responses. This study examined social workers' perceptions of community violence, protective factors, and resilience, as well as examined how these perceptions influence the treatment that they provide to their clients. The study also asked participants about the nature of disclosures of their clients as well as the way in which they typically screen or assess new clients for community violence exposure.

Sample

Over the course of 30 days, participants were recruited via a snowball sampling method. The researcher used personal and professional contacts in the field of social work to distribute the survey by email. The inclusion criteria for participation included: 1) Holding an MSW from an accredited school, 2) Having license to practice social work, 3) 2 years or more experience post MSW graduation, and, 4) Current work (1 year or more) with children and/or adolescents impacted by community violence. Those who did not meet all of these criteria or did not agree to the Informed Consent were excluded from participation. The recruitment email (Appendix A) in part stated:

> I am writing to request your assistance in helping me to recruit potential participants for my research study which assists in the completion of my degree. You are encouraged to participate if you meet requirements. You may also help me by helping to identify qualified persons who may be interested in participating and forwarding them this email.

By sending this email to both potential participants and those who likely could forward it to more potential participants, participation in this research was maximized in order to achieve the desired N=25. Additionally, each potential participant would receive my original letter which asked them to forward to any persons who may be interested and/or qualified to participate.

Instruments

The researcher developed the instrument for the study (Appendix D). There is not an existing measurement that examines both community violence and resiliency. This mixed methods research included a series of demographic questions as well as a series of short-answer questions. The demographic questions aimed to gather information about

participants and their work setting. This section included questions about participants'

gender, age, masters' institution, year of graduation, the type of agency for which they

work, the population with whom they work, and the city and state in which they work.

To collect information on participants regarding their perceptions of community violence

and resilience, 14 short-answer questions were used. The questions included focused

questions related to community violence, resilience, screening, practice, and advice for

new social workers working with children and families exposed to community violence

(see Appendix D for more details).

Data Collection

A Human Subjects Application was submitted to and approved by the Smith

College School for Social Work Human Subjects Review Committee (Appendix C).

Over the course of 30 days, participants were able to access the survey at

www.surveymonkey.com. Survey Monkey is a secure internet survey hosting website.

Survey Monkey has been commonly used by past Smith College School for Social Work

students and it was chosen for its simplicity. The setup of the survey was tested prior to

the link being sent out to actual participants to ensure ease of use. All completed surveys

were collected and submitted electronically.

All participants were recruited by email. Potential participants were provided

essential information about the research, the contact information for this researcher, and a

link to the online survey.   When a potential participant visited the Survey Monkey link,

they were initially brought to a screen thanking them for their interest in the study. Next

they answered five questions regarding the inclusion criteria for the study to determine

eligibility. If they did not meet criteria, they were sent to a page that informed them that

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they were not eligible to participate in this study If they did meet criteria, they were

directed to the Informed Consent (Appendix B). After reading the Informed Consent,

they could either choose "I agree" to begin participation in the survey or "I do not agree"

which would result in them being automatically directed to the end of the survey and

thanking them for their interest. When a participant chose "I agree" they were brought to

the demographics page of the survey and answered questions regarding gender, age,

where they received their master's degree from and in what year, the type of agency in

which they practice, the population with whom they practice, and the location of their

agency.

After completing the demographics page, participants were brought to the short-

answer section of the survey. This section included 14 questions, with each question

having a separate page. Participants were required to answer each question before

advancing to the following question, as this was done to prevent participants from

skipping questions. When participants reached the end of the questions, they were

provided with a question which stated "Is there anything else you would like to say on the

topic of community violence, resilience, and protective factors?" This was the only

question which did not require a response in order to continue. After this, participants

were directed to a page which thanked them for their participation.

Data Analysis

Data obtained during this survey was then analyzed by the researcher. First, the

researcher read through the responses to each question individually in order to gather

themes that came through in each response. The major themes were then looked at across

multiple questions, so as to provide a more organized account of what was shared by

various participants. Questions that were similar or that elicited similar responses were then grouped together. This occurred with a number of the questions in the study. Additionally, multiple quotes were identified that best represented general themes. Lastly, the data was looked over for comments and responses that did not necessarily fit into any of the major themes. These outlier responses were recorded and included in the findings section of this paper.

<center>*Ethics and Safeguards*</center>

The information that participants provided was handled confidentially and anonymously. Although Survey Monkey does record IP addresses in order to identify a set of responses from a given participant, this information is not available to the researcher. The data results were available only to the researcher and research advisor. Participants in this study were encouraged not to include any identifying information about themselves or their clients. In the case that any was included, it was omitted from the final version of this research paper. All data provided will be stored electronically on a password protected system for a period of three years or until no longer needed.

Although they were minimal, possible risks for participating in this study included stimulation of concerns that participants were no adequately addressing community violence in their practice. This possibility for dissonance was addressed in the informed consent. Participants were allowed to withdraw from the study at any time.

CHAPTER IV

FINDINGS

This research study examined social workers' perceptions of community violence exposure and resilience in children and adolescents. The study also examined how social workers tend to assess and treat their clients who have had experiences with community violence. The study findings will be preceded by a description of the demographics of those who participated in this study. This will include gender, age, master's institution, year of graduation, and geographic locations in which participants practice.

Participant Demographics

The participants in this sample were social workers who work with children and/or adolescents who may be exposed to community violence. Twenty-five participants completed the study, and although more completed a portion of the study, only those who completed the study in entirety are included.

In regards to gender, all participants were female (96%) with the exception of one male (4%). Participants varied quite a bit more in age, with a mean of 40 years, a median of 37 years, and a range of 25-60. Of the 25 participants, 13 (52%) practiced in the Boston area, 9 (36%) practiced in the San Francisco/Oakland Bay Area, 2 (8%) practiced in New York City, and 1 (4%) practiced in New Britain, CT.

Participants received their Masters of Social Work degrees from a variety of schools which included: 4 (16%) from Boston University, 3 (12%) from the University of California at Berkeley, 3 (12%) from Boston College, 2 (8%) from the University of Michigan, 2 (8%) from the University of California at Los Angeles, 2 (8%) from Simmons College, 2 (8%) from Smith College, 2 (8%) from Columbia University, 1 (4%)

from the University of Denver, (4%) 1 from the University of Chicago, 1 (4%) from New York University, 1 (4%) from Wheelock College, and 1 (4%) from Salem State. Participants received Masters degrees as early as 1974 and as late as 2007, with 2 participants graduating in the seventies (1970-1979, 8%), 5 in the eighties (1980-1989, 20%), 8 in the nineties (1990-1999, 32%), and 10 in the current decade (2000-2009, 40%).

Agency, Population, and Client Demographics

Participants were also asked about the population which they work with in the demographic section. As clinicians often work with multiple populations, participants were allowed to respond to as many populations as applied to them. In this study, 23 (92%) of participants reported working with children, 18 (72%) reported working with adolescents, and 22 (88%) reported that they worked with the family as well.

Lastly, participants in this research worked in a variety of settings or agencies. In this section, participants were allowed to pick multiple sites if applicable. Of the participants, 6 (24%) responded to working in a community based agency, 12 (48%) reported that they worked at a hospital based agency, 2 (8%) reported working at a school based site, and 5 (20%) reported working at multiple sites.

Participants reported a range of clients that varied in terms of age, gender, and socioeconomic status, as well racial and ethnic backgrounds. In regards to age, participants reported working with clients that ranged from "birth to 20 years old" but many respondents also mentioned working with parents of these clients directly as well. One participant identified working only with female clients while all others did not specify working primarily with either gender. Four participants identified that their

clients tended to be of low socioeconomic standing, although this was identified in different ways which ranged from a description of clients as "low-income", to expressing that they were "below the poverty line", or just simply describing them as "poor." All participants identified that their clients were of low socioeconomic status.

Racial background of participants' clients tended to be the most diverse in terms of demographics. Participants mentioned serving clients who were African-American, Black, Caucasian, White, Latino, Hispanic, Native American, Asian-Pacific Islander, Asian, and Somali. Less specifically, a few participants wrote that their clients were "all students of color" or "mostly minorities."

Lastly, one participant reported that her clients were primarily from "marginalized" populations. As it is unclear exactly what was meant by this response, it is possible that it refers to the oppression felt by those who occupy a disadvantaged social standing in this society.

Overview of Survey Questions

In addition to the aforementioned demographic questions, agency, and client population questions, participants in this survey were also asked to define key terms, specifically resilience and community violence. Additionally, they were asked questions about their experiences working with clients exposed to community violence and how they typically assess and treat these clients. Lastly, the survey asked questions about participants' perceptions of the impact of community violence exposure, asked participants for recommendations for new clinicians working with this population, and provided participants an opportunity to provide any additional information that they deemed pertinent.

Definition of Community Violence

Participants were asked to define community violence at the outset of this research. One major theme that was seen in responses to this question was the perception of the location of community violence. In other words, the definition of "community" itself varied among respondents. Although some participants specified that community violence occurs "outside of the home", some included domestic violence and child abuse in their responses. Four participants specified that the violence must be taking place "outside of the home" or "outside the family" in order for it to be considered "community violence." Those who mentioned specific locations included the streets, schools, churches, neighborhoods, community centers, businesses, homes, and bus stations.

Five participants specifically mentioned the word "gang" in their responses, while three participants mentioned "violence by law enforcement", which specifically refers to violent acts committed by police officers toward other members of the community.

Participants' definition of "violence" in this question included a variety of acts including homicide, drug trafficking, sexual exploitation, assault, burglaries, property crimes, shootings, fights, gang violence, familial violence, rape, police brutality, destruction of property, teen on teen violence in schools, domestic abuse, molestation, and violence against animals. Less specifically, one participant responded that community violence was "any incident in which bodily harm is either threatened or perpetrated, by any means" and another stated "community violence is any kind of crime or unsafe/dangerous situation that is in the every day lives of children and families in

urban areas, where the members of the community are attacking each other." These sentiments were echoed by a number of other participants.

Definition of Resilience

Participants in this research were asked to define resilience at the outset of the study. One major theme that came through in their responses was the necessity of a challenge or obstacle in order for resilience to exist. This was mentioned by nearly every respondent and is exemplified by the participant who responded that resilience is "the ability to function at a meaningful level and find success… despite living with stressful and/or traumatic environmental factors." This same concept is shown by another respondent who stated that "resilience is being able to bounce back, and overcome many obstacles."

The second major theme that was present in a majority of the responses was that resilience means to obtain a certain level of functioning (possibly one that is deemed "normal" by the rest of society). Participants referred to "function(ing) at a normal level", "one's ability to continue on in life and go in a positive direction", and having a "strong enough sense of themselves to keep on their path." One respondent mentioned that resilience itself is more than just returning to a level of functioning that one might refer to as a "normal", stating that resilience is "the ability over time to recover from and even thrive under difficult life circumstances."

Experiences with Community Violence

Participants in the study were asked about their direct experiences with community violence in their clinical work. As it was a pre-requisite for participation, every participant reported that clients had disclosed community violence experiences. A

major theme in this response was the severity of the violence that participants' clients had experienced. Seventeen (78%) of the participants reported that clients had directly/indirectly experienced shootings and/or homicide. The severity of violence was best summed up by one participant who simply said: "they have been to too many funerals." Another respondent described their experiences with community violence in their clinical work as "too many to tell" while another reported that "most all children are aware of a relative or family friend who has died due to community violence."

Beyond shootings and homicides, participants mentioned working with clients who were impacted by gang violence, sexual exploitation, stabbings, being hit by or having stray bullets enter their apartment, assaults, robbery, school fights, violence by police, being jumped into/out of gangs, fighting for sport and/or for survival. One participant also reported that they worked with clients who ended up in the witness protection program "due to threats on their families from 'snitching'" after they had witnessed community violence. Another participant reported: "40% of my caseload has been affected in some way by community violence and that almost my entire caseload lives in communities that have a history of community violence."

Assessment of Community Violence

Participants in this study were asked about how they typically assess for community violence exposure with their clients. There were two questions that touched on this, one specifying if the social worker verbally assessed, and another specifying the assessment forms typically used. In general, participants were more likely to screen verbally as roughly half of the participants stated that their assessment forms do not have any questions that specifically mention community violence. A number of participants

stated that their forms mention exposure to violence in a general sense, not specific to community violence. Although many participants responded with an initial "yes" to the question regarding the intake forms, a more in depth analysis of responses reveals that many of these clinicians answered "yes" although their forms do not actually mention community violence. Some examples of this are the participant who said "yes, specific questions about domestic violence and if the child has witnessed violence" and the participant who reported "yes, we ask youth ages 11+ if they are harassed, teased, or bullied, and if they are afraid to go to school or other places in their neighborhood."

One participant reported their dissatisfaction with the current intake forms stating that their "risk/protective factors screening has a question about it, ONE, I think this is a problem." Moving on to verbal assessment, this same sense of dissatisfaction continued. One participant reported that the frequency with which they verbally assess is "not enough", continuing to say "it is not on our 'list'. We generally see them for what they come in for, but this is a great prod to include questions related to community violence in our assessment."

The question on verbal assessment saw a greater degree of participants screening their clients for community violence exposure. This is seen by participants reporting that they ask their clients (both parents and children) questions such as: 1) "What is it like in your neighborhood?" 2) "Do you worry about letting your children play outside?" 3) "Do you feel safe in your neighborhood?" 4) "Do you ever get in fights or witness them?" These types of questions were mentioned by a number of participants. Another participant specified that they start by asking questions "surrounding experiences of sexual, physical, domestic, and community violence" as well as "identifying knowledge

of the existence of violence within the community." The consistency of screening was not across the board however, with one participant stating: "With children who live in the city, I ask about their experiences with gangs and gang related activities." This same sentiment was echoed by a participant who said that their screening with clients "depends on what neighborhood or community they are from." Another mentioned that they do not verbally screen for community violence "as a routine", but is "open to hearing client's experiences." Lastly, one participant mentioned that they routinely ask clients about community violence experiences, "Sometimes the question is unnecessary because trauma due to violence is the reason for the referral."

Screening for Community Violence

Next, if applicable, participants were asked why they believed that they did not screen for community violence. Although most participants reported that they did screen (be it verbally or via the intake form), those who proposed reasons had some interesting ideas. One participant responded by saying: "It is not that I am not aware of it, maybe it's an assumption that pretty much all of our clients within the hospital have been exposed" to community violence. Another participant hypothesized that maybe her agency does not screen because they "are overwhelmed and due to vicarious trauma" while another suggested that "this continues to be a topic in which many are uncomfortable 'holding' and addressing with children and adolescents especially." This participant continued to say that "the act of not asking is reflective of the desire not to know." The difficulty of talking to children about community violence was again brought up by a participant who responded that they "think it is hard for people to ask

young children or adolescents about this topic" and continued to say that "the danger of this is then we are colluding with others about this being a normal part of life."

Impact of Community Violence on Children and Adolescents

Participants were then asked how they have seen community violence exposure impact children and adolescents in their clinical work. A variety of issues were mentioned such as hypervigilance, trust and attachment issues, post-traumatic stress disorder symptoms and depression symptoms, externalizing behaviors, and an overall numbing to the violence. Additionally, some participants mentioned that on a more basic level, community violence prevents children from being able to play outside which could be tied to physical health concerns.

Hypervigilance was mentioned as a potential consequence of community violence exposure by a number of participants. This was referred to directly by name, or as a "heightened state of arousal", or "anxiety". One participant replied that this hypervigilance leads to children "not being able to sleep" and not being "able to relax enough to really integrate the experiences in their lives" while another said that it creates children who are "hyper-aware of surroundings" and "at heightened-alert for their safety" which ultimately results in their "brain (being) developed differently than a child growing up in a safer community." Lastly, another participant mentioned that children do not have "freedom to travel their community without heightened awareness about where they are going and with whom they keep company."

Trust and attachment issues were another frequently mentioned possible impact of community violence exposure. As one participant said, "children grow up not being

entirely certain whom in the neighborhood to trust." Another said community violence exposure "effects how they build relationships with peers and adults."

Post-traumatic stress disorder symptoms (specifically depression) were mentioned often by participants in this study. One participant stated that this is common when children "internalize" the effects of the violence. Other participants mentioned feelings of "helplessness" and problems with "self-esteem regulation."

Another prominent theme is acting out/externalizing problems associated with exposure to community violence. Participants mentioned court involvement, taking part in violence and/or other crimes, as well as risk-taking behaviors as potential results of exposure to community violence.

Another theme in this section was that clients often become "numb" to all the violence that happens in these communities. In regards to this "numbing," one participant stated that it was "worrisome that people are not responding to violence in a more shocking manner." Another participant noted that adolescents can often feel "hopeless" and tend to "carry a sense that this is just the way life is." Another suggested that when adolescents "accept it" then they may "affiliate themselves with gangs for protection."

Lastly, one participant best summed up the impact of community violence exposure by saying that it creates "complex trauma in our kids, who often have past traumas they are still coping with." Another participant stated: "In Oakland, community violence (either recent, the memory, or the threat of it) is most often on people's minds."

Perceptions of Protective Factors

Social workers who participated in this study were asked, in their clinical experiences with community violence, what they have seen to be most helpful in promoting resilience. Similarly, they were also asked what they see as protective factors against the impact of community violence. A majority of respondents in this study featured the importance of social support in their responses. This opinion was demonstrated using a number of different terms, which included: "one positive adult," "one or two people closely connected," "having someone who believes in them," "a concerned adult," "consistent caregivers," "a support network of family members, adults and peers," and "a strong adult or parental figure." Other participants mentioned the importance of "someone that will stay with the child over an extended period of time and sincerely take an interest in the child's life" as well as the positive "love and support of family caregivers or important adults."

A few participants mentioned that those providing social support should help children to process and integrate the trauma in order to facilitate resilience in children exposed to community violence. For instance, one mentioned the importance of having adults "acknowledge the trauma and allowing children to talk about it." Another respondent said that the "family's response is key" in order to "validate" and "help the child make sense of the event." The "response of the adults around the child is HUGE!", said another participant. This sentiment was echoed by another participant who described "how the family talks, responds, and treats the problem" as the "most important protective factor." According to one participant, it is important that "trauma of any kind is addressed and treated, not denied" within the family setting.

In addition to social support, some participants mentioned the significance of attachment relationships. One participant reported that "good attachments" were important in regards to fostering resilience. Another mentioned "secure and stable relationships."

Another theme that was present in responses was that of the importance of a strength-based approach. One participant stated: "I think a big part of promoting resilience is focusing very adamantly on their strengths." Another cited that it is "important to identify the strengths of these youth and the ways in which they have developed ego strengths, had significant attachments, built skills, are able to cope and function."

A limited number of participants also mentioned therapeutic services in their responses. One participant called group therapy "a safe place to practice and explore" while another touched on the importance of "community services that are easily accessible and that do not contribute to the victimization of people (long wait lists, further beurocracy, etc)." Additionally, the importance of "early referral and treatment" was also mentioned by a participant.

A response that falls under a number of themes was that of the participant who stated that children and adolescents exposed to community violence should "have a place where they can honestly talk about their experiences and the myriad of conflicted feelings." Another important response which focuses on the importance of addressing the trauma came from a participant who said that "Ignoring the problem means colluding with the notion that community violence is acceptable."

Modality of Treatment

Participants were asked about the type of treatment that they typically utilize in their work. Responses ranged quite a bit, including one respondent who said they were "not sure." Primarily and most frequent, cognitive behavioral therapy and play therapy were mentioned. A number of participants stated that they used individual, group, family therapy, or some combination of the three. Crisis intervention and case management were both mentioned in this section numerous times as well.

Suggestions for New Clinicians

Participants were asked what they would suggest to new clinicians who would be working with children and families who have witnessed or experienced community violence. The two major themes that emerged from this question were 1) the importance of self care and 2) the importance of supervision. One participant mentioned that clinicians should "always have supervision no matter how long (they) work in this field." Another participant said that clinicians should always "utilize supervision/team case conference opportunities." The importance of self-care was mentioned in different ways which range from the participant who simply said "take care of yourself" to the participant who said "take self-care very seriously! Remember that you have to really care for yourself if you are going to care for others who often do not know how to care for themselves!" The importance of self-care was explained by one participant who described experiences with children and adolescents exposed to community violence as "very stressful work."

The importance of a non-judgmental stance was also mentioned by a number of participants. One participant mentioned it is important to "assume a non-blaming/judging

standpoint from the beginning." Another participant stated that "'getting out' of the violence isn't an easy thing to do" and recommended that clinicians not "be judgmental if (their clients) continue to live in a community with violence."

The theme of "listening" and attunement to clients was included in numerous responses. Being "ready to listen whenever they are ready to share their story" as well as "being empathic, listening, and giving silences and grief space when needed" both were included by participants in this study.

Other participants gave a variety of advice which touched on the importance of "intensive case management", as well as "linking to a variety of accessible community-based services" and using a systems approach to treat clients as well. Additionally, some participants mentioned the role that social workers play when it comes to initiating systemic change which can be seen in the responses that mention "making connections" with relevant local organizations. Lastly, one participant mentioned that clinicians should "use your screening tool and then weave those experiences into the narratives children tell or create."

Conclusion

The findings of this study show that social workers tend to have varying opinions about community violence and resilience. Additionally, findings of this study show that social workers tend to assess community violence in varying degrees and treat community violence in a variety of different ways. The results of this exploratory study were consistent with past literature, which will be discussed at greater length in the next chapter of this thesis project. The next chapter will evaluate these findings, compare

them to the literature, and discuss their importance of this research to the field of social

work.

CHAPTER V

DISCUSSION

This primarily qualitative study was aimed at determining social workers'

perceptions of community violence and resilience in children and adolescents. In

addition to their perceptions, this thesis project examined how social workers typically

assess and treat their clients who have potentially been impacted by community violence

exposure. Prior to this study, there was not existing research examining both social

workers' perceptions and assessment/treatment. Findings of this study revealed a number

of themes which will be discussed at length in this section. These themes provide helpful

insight into social workers' ideas about community violence, resilience, and screening for

community violence exposure. They also offer some insight to the connections between

these perceptions and the frequency and quality of screening and assessment. This

chapter will discuss in detail three major themes. The first theme discussed is the

prevalence of community violence. The second theme is social workers' hesitance to

work around issues of community violence, as well as some clear misconception about

what it means to address issues of community violence in the therapeutic relationship.

The last and third theme is the absence of intake/assessment forms which mention and

screen for community violence exposure.

Prevalence of Community Violence

As mentioned earlier in this paper, community violence impacts far too many

children and adolescents in this country and around the world. Research conducted by

the Centers for Disease Control and Prevention (2008) was supported by participants in

this study, who spoke of the types of experiences their clients have endured during their

lives. In this thesis project, 78% of participants reported that they have worked with clients who experienced a shooting or homicide (either directly or indirectly), making it clear that community violence is extremely pervasive. In addition to murder and gunshots, participants reported a range of other experiences which certainly fall within the spectrum of community violence. These experiences range from being "jumped" and robbed to having stray bullets coming through their living rooms. As this research clearly points out, community violence is a part of daily life for so many children and adolescents. It is also clear that many social workers are working with community violence issues in their practice.

Assessment of Community Violence Exposure

Social Workers play an extremely important role when it comes to assessing for traumatic life experiences with their clients. While many assessment and intake forms traditionally include questions about domestic violence, child abuse, and intimate partner violence, there is a concerning deficiency in forms that ask about community violence exposure. It is important that social workers do more to practice in a way that fully considers community violence and its impact. If social workers continue to ignore community violence, not only are they failing at providing service to a traumatized population, they are sending the message that violence within communities is not noteworthy, and in many ways, acceptable.

Although this research found that social workers were more likely to screen for community violence exposure verbally, the manner in which they did so was often less than satisfactory. One participant mentioned that they would ask clients about their experiences with violence in general, not specific to community violence. In many cases,

clients themselves may be so accustomed to the community violence in their neighborhood that they unconsciously do not mention their experiences with community violence when asked about violence in general. Another participant mentioned that they "ask youth ages 11+ if they are harassed, teased, or bullied, and if they are afraid to go to school or other places in their neighborhood." A similar inadequate method of screening was mentioned by another participant who also reported that they do verbally screen for community violence. This participant reported that they ask "specific questions about domestic violence and (they ask) if the child has witnessed violence in their home." While the aforementioned participants are claiming that they do in fact screen for community violence, they are falling far short of adequate screening practices. These practices are insufficient because they are not specifically asking about community violence. While asking if a child feels safe in their neighborhood or if the child is bullied are good questions to ask, it is only one small part of a larger assessment that should be taking place.

Participants reported screening for community violence in other ways as well. One social worker reported asking about clients' "experiences with gangs and gang related activities." While this method of screening occasionally may provide some insight, it likely most often does not catch clients who have had experiences with community violence, both direct and indirect, that have nothing to do with gangs. The view that community violence is limited to gang activity seems to oversimplify a complex and vital social issue. This lack of understanding, which is in many ways a stereotype, helps to understand why verbal screening is falling far short in many cases. Two participants mentioned in their responses that they screen clients depending on the

neighborhood where the client lives. It is important for clinicians to remember that children from all neighborhoods may be impacted by community violence. For this reason, clinicians should be screening all of their clients, regardless of where they live, as this is essential in order to understand the many different ways in which community violence can impact a child. When mandated screening is not in place, the opportunity for unconscious racism to manifest itself is quite simply too great. This inherent racism is clearly evident when clinicians base their decisions about screening on the neighborhood a child lives.

Another clinician who participated in the study stated that they often do not need to assess for community violence as the referral for services was based on an incidence of community violence. Again, this answer shows a misunderstanding of the importance of fully screening for community violence exposure. When a child is referred due to an experience with community violence, it seems common sense to assess for other similar experiences. If a clinician is referred a client who was sexually abused, one of the first questions this clinician might ask is: "Did this child have other similar experiences?" This clinician would likely want to know if this was an isolated incidence, or something more chronic, and would use the therapy to work through these experiences with the client. As this is the typical procedure with sexual or physical abuse, and domestic violence, why should community violence exposure be any different?

Current Intake Form Screening Practices

According to the participants in this study, roughly half of them work in agencies that do not include any questions about community violence exposure on the intake forms. It is noteworthy that all of these participants claimed to be working with clients

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who had experienced community violence. Although half the participants in this study

mentioned screening forms that included issues of community violence, many of the

examples that they provided actually did very little to screen or did not screen specifically

for community violence at all. For instance, one participant replied "yes" when asked if

their agency intake forms mention community violence, but then elaborated that they ask

about violence exposure in a general sense. This is a perfect example of the failure to

properly screen children for community violence exposure. Questions must address it

directly, rather than screening for violence "in general." Additionally, there must be a

number of questions that cover community violence, rather than just one as was often

used by participants in this study. Suggestions for future screening practices will be

discussed later in this chapter.

Explanations for Lack of Assessment

Participants mentioned a number of reasons for the lack of screening and

assessment. One participant suggested that their agency may not be screening because of

the "assumption that pretty much all of our clients within the hospital have been exposed"

to community violence. It is quite possible that this assumption does exist for many

clinicians; however it does little to justify ignoring the problem. Another participant

mentioned that not asking about community violence is actually a reflection of "the

desire not to know." If this is the case, then it seems important for trainings that directly

address this fact. This participant continued to say that social workers are overwhelmed

as well as mentioning "vicarious trauma." It is very possible that some social workers

consciously or unconsciously ignore community violence as a way to protect themselves

from it. As there are a myriad of other issues that clients often face, maybe some social

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workers can only hold so much at once and the emphasis simply does not fall on community violence. As vicarious trauma and being overwhelmed are both very real issues that social workers face, it seems as though more must be done to promote self-care and to curb the impact of vicarious traumatization and burnout. One possible way that this could be addressed is through further training and workshops on vicarious trauma. A suggestion is to encourage the field to expand research to focus on ways that social workers cope with vicarious trauma when working with children and adolescents exposed to community violence.

Impact of Community Violence Exposure

Participants in this study were familiar with past research in regards to the impact that experiencing community violence can have upon children and adolescents. Participants mentioned a variety of internalizing and externalizing symptoms, such as depression and hypervigilence. One participant stated that children who are exposed to community violence no longer feel "complete freedom to travel their community with out heightened awareness about where they are going and with whom they keep company." In terms of future work, participants were well educated on the impact of community violence and trauma, but require more training and information specifically on the ways in which community violence is assessed and treated.

Protective Factors

When participants were asked about what they have observed that acts as a buffer from the detrimental impact of community violence, they mentioned multiple factors, most of which were consistent with existing research. For instance, the importance of social support was included in a majority of participants' answers. Although this was

mentioned in varying terms, the general theme was present for most participants. For instance, one participant identified a "support network of family members, adults and peers" as the most important protective factor. Another important distinction made by some participants was the role of those providing social support. In addition to being there for the child, these participants thought "how the family talks, responds, and treats the problem is the most important." This participant is referring to the importance of integrating the traumatic experience(s) into the child's life. In addition to social support, the importance of secure attachments and religiosity or spirituality was also mentioned, but to a lesser degree.

Advice for Future Screening Practices

As the responses to this research have shown, many social workers do not properly screen for community violence exposure. As this is such an important issue in the field of social work, screening practices must improve. Better screening will lead to overall better treatment, and an improvement in the service being provided to communities, especially communities of lower socioeconomic status where a majority of community violence takes place.

As noted previously in this paper, when screening is not part of the intake it becomes the prerogative of each social worker. Unfortunately, this lends itself to the preconceived notions and biases that exist within each individual. When clinicians believe that community violence only happens in urban areas and they choose to not screen a child from the suburbs, this represents a failure in providing proper service. It is also quite possible that this child's cousin or extended family lives in a more violent community and was affected by violence. Regardless of the neighborhood a child comes

from, social workers must screen for community violence exposure. If only children who live in "bad areas" are being talked to about their community violence exposure, then social workers are failing at practicing in a culturally competent and culturally responsible way.

The most important way to improve screening is to implement screening tools that are used at every intake. Much in the way tools exist to screen for domestic violence and child abuse, tools must be created to screen for community violence. The necessity of screening was mentioned by one participant who stated that it is "important to integrate (screening) into assessment and treatment planning." Another participant divulged that they do not screen for community violence unless it is the presenting problem, but referred to this research as "a great prod to include questions related to community violence in our assessment." As the importance of screening has clearly been acknowledged, creating a screening tool is the next step.

Recommended questions that would help to screen for community violence include: 1) Do you feel safe in your neighborhood? In your school? 2) Do you ever see people fighting/arguing/yelling while in public? 3) Have any of your friends or family members talked about seeing anything like this happen? 4) Have any of your friends or family members been assaulted, robbed, stabbed, or shot? 5) Have you ever heard gunshots? While it is obvious that the way in which questions were phrased would need to be age appropriate, this short list provides some initial insight into types of questions that may be useful in screening for community violence exposure. Additionally, the aforementioned questions serve only as a guide, and further research is necessary to

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develop an effective screening instrument. Agencies should also work together to create screening tools that are age appropriate for their clients.

Implications for Practice

As many of the social workers who participated in this study graduated from prestigious institutions, it serves as a reminder that these and all social work schools need to integrate education on community violence into their curriculum. Social work schools need to more efficiently dismantle stereotypes about community violence, as well as providing information about its impact and prevalence. Throughout life, people are often bombarded with stereotypes about their world and those with whom they interact. It is the duty of social work schools to address this as an essential part of educating those who will be entering this "helping profession." This is an important and necessary part of social work education that seems to be often forgotten and it is hoped that this research serves as a reminder.

Conclusion

This research discovered much about the perceptions of community violence and resilience that social workers hold. Additionally, participants' methods of assessment and screening were discussed. Although participants seemed to be well versed in their understanding of community violence, this knowledge did not translate to proper screening and treatment techniques. In the future, agencies and social work schools must do more to provide education and training on community violence. Additionally, it is recommended that agencies adopt a mandatory screening tool with which to assess their clients.

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Appendix A

Recruitment Email

Dear Friends and Colleagues,

As many of you may know, I am currently a candidate for a Masters degree in Social Work from Smith College School for Social Work. I am writing to request your assistance in helping me to recruit potential participants for my research study which assists in the completion of my degree. You are encouraged to participate if you meet requirements. You may also help me by helping to identify qualified persons who may be interested in participating and forwarding them this email.

This study aims to explore a number of things about the way in which social workers respond to the issue of community violence. In order to be qualified, potential participants must hold Master's Degree in Social Work from an accredited school, be licensed to practice Social Work, be currently working with children and adolescents impacted by Community Violence (duration 1 year or more), and have at least 2 years post-graduate work experience.

Qualified participants will be asked to provide basic demographic information as well as answer approximately 14 short answer questions. All information will be collected via online survey and participants should expect to take about 30 to 45 minutes to complete the survey. The demographic section will ask participants to provide general information about themselves and the population who they primarily serve. The short answer section of this survey will ask questions related to community violence, resilience, their clients' experiences, as well as screening and treatment of community violence. Although these questions are labeled as "short answer", there will be no limit on the length of responses provided by participants. Additionally, space will be provided for participants to express additional thoughts or experiences at the end of the survey. This survey will be anonymous as no names or specific identifying information will be asked for.

In order to help me recruit potential participants, I am asking that you forward this information to any licensed clinical social workers that you may know (including colleagues, friends, and family) who may be willing to participate.

Please feel free to contact me directly with any questions or concerns about participation.

Thank you very much in advance for making this project a success.

Sincerely,

Matthew Warford

Second Year Masters Student, Smith College School for Social Work
(401) 465-8364
communityviolencestudy@gmail.com
747 52nd Street, Oakland CA, 94609

Appendix B

Informed Consent Letter

Dear Participant,

     My name is Matthew Warford and I am a student at Smith College School for Social Work, currently working to obtain my Masters Degree. I am conducting a research project examining Resilience and Community Violence Exposure and how it is being screened for and treated in children and adolescents by social workers. All information collected for this research will be used for my MSW Thesis, as well as for presentation and publication.

     Participation in this study will take approximately between 30 and 45 minutes. In order to participate, you must (1) hold an Master's degree in social work (MSW) from an accredited school, (2) currently have a license to practice as a clinical social worker, (3) have worked with children exposed to community violence for at least one year, (4) are currently working with children exposed to community violence, and (5) have had at least two years of post-graduate experience.

     For your participation in this research, you will complete demographic information for yourself and for your clients, as well as roughly 12 open ended short answer questions. Please do not use any names or identifying information when discussing specific cases in your responses.

     Participating in this research may stimulate concern or a realization that you are not practicing in a way which fully considers the importance of community violence and resilience. These dissonant feelings could produce stress and self-blame for problems that your clients face.

     Conversely, these dissonant feelings could help to inform your practice which in turn may make you a more attuned and effective clinician. On a larger scale, participating in this research benefits the entire social work community because it helps to fill a gap in the current literature. No financial compensation will be provided for your participation in this research.

     All information that you provide will be kept either locked or stored electronically on a password protected device. This data will be kept for three (3) years as required by Federal law, at which point it will be either destroyed or continue to be kept securely as previously stated if they are needed for further research analysis. After this three (3) year period has expired, the data will be destroyed if it is not of use to this researcher. The data that I obtain will be available to myself as well as my Research Advisor, Shella Dennery.

     Participation in this research is voluntary, however as it is anonymous it will not be possible to withdraw from participation once you submit your survey. In addition, you may choose not to answer any of the questions and you will not be penalized in any way. At any point if you have questions about your participation in this research, you are encouraged to contact me by phone (401 465-8364) or by email at

communityviolencestudy@gmail.com. Should you have any concerns about your rights or about any other facet of the study, you are encouraged to contact me or to call the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

SELECTING "YES, I AGREE TO THE ABOVE CONSENT FORM" INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY

Appendix C

Human Subjects Approval Letter

March 5, 2009

Matthew Warford

Dear Matthew,

Your final revision has been reviewed and everything is now in order. We are happy to give final approval to your study. You have made your screening process very clear.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Shella Dennery, Research Advisor

Appendix D

Survey

<u>Demographic Information</u>

Gender:
Male_____
Female_____

Age:

Masters Institution:

Year of Graduation:

Type of Agency / Setting of Practice:
Community Based_____
Private Practice_____
School Based_____
Hospital Based____
Other____

Population(check all that apply):
Children_____
Adolescents_____
Family____
Other____

City, State:

<u>Interview Guide</u>

1. Describe the demographics of your current case load

2. How would you define community violence?

3. What does "resilience" mean to you?

4. What types of experiences have you had with community violence in your clinical work?

5. Have your clients disclosed experiences of community violence? (i.e. being witnesses or victims, or having a friend or relative be victimized)

6. Do you verbally assess for community violence exposure in any way? If yes, what do you ask?

7. Do your intake forms include any questions that address community violence? If yes, what are they?

8. If you do not screen for community violence exposure, why do you think that is?

9. From your clinical experiences, how does community violence impact and effect children and adolescents? What are the differences depending on age of the client?

10. In your work with children exposed to community violence, what factors would you say are most helpful in promoting resilience? Is your answer based on experience, knowledge of research, or both?

11. What do you see as protective factors against the impact of community violence for children and adolescents?

12. What modality or modalities do you employ to treat your clients?

13. What suggestions do you have for new clinicians working with children or families who have witnessed or experienced community violence?

14. Is there anything else you would like to say on the topic of community violence, resiliency, and protective factors?