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A clinical response to a community issue : exploring Hartford's youth exposure to community violence in a community-based agency

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ABSTRACT

The purpose of this study was to explore what clinicians and managers at a Hartford, Connecticut community-based mental health agency are doing to integrate an effective collaboration between micro, mezzo, and macro level interventions to help youth clients residing in Hartford build competent communities. Fellin, (as cited in Hardcastle, 2011) defined a competent community as "one that has the ability to respond to a wide range of member needs and solve its problems and challenges of daily living" (p.96). Given the increased rate of community violence in Hartford in 2015, this research is especially important because the majority of clients and families receiving services at the agency may have been traumatized by these occurrences.

Three focus group discussions were conducted for data collection. Data analysis was completed by observing patterns and/or themes in responses from participants. Clinicians and managers shared their perspectives of Hartford's community violence and how this influences the clinical interventions used during sessions, as well as what they perceive their role to be in addressing a community wide issue.

Results of this study confirm that community violence is a widespread issue for Hartford youth. Clinicians' and managers' perspectives of this issue does influence their ideas about Hartford's youth, and thus affect the clinical interventions they use (or don't use) during sessions

with clients. Findings also conclude that clinicians and managers assume variant advocacy and

counseling positions in supporting youth from their position within the agency.

A CLINICAL RESPONSE TO A COMMUNITY ISSUE: EXPLORING HARTFORD'S YOUTH EXPOSURE TO COMMUNITY VIOLENCE IN A COMMUNITY-BASED AGENCY

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

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CHAPTER I

Introduction

Hartford, the capital of Connecticut and once a wealthy city, is now known as one of the poorest cities in the country; "almost one third of the population and almost half of its children live below the poverty level" (De Avila, 2012, September 30). Neighborhoods like Hartford that are "characterized by social and economic impoverishment hold substantial risks for families rearing children which can place children and youth in a 'double jeopardy' of violence and exposure to poverty" (Guterman & Cameron, 1997, p.502). According to a September 7, 2015 article in the Hartford Courant Newspaper ("Police ID Victim," 2015), "Connecticut's capitol city currently has the most homicides in New England with 25 homicides. Boston with a population five times greater than Hartford's has recorded 23 murders. Springfield, with about 25,000 more residents is third with 14." Patrick Johnson, online reporter for www.masslive.com also reported on September 7, 2015 that Hartford's rate has "surpassed 2014 year's [murder] total of 19." Homicides are just one of the many types of community violence happening in Hartford; other violent exposures include suicides, gang-related violence, and robberies throughout the city. Hartford's officials are urging the community to find ways to reduce violence, and many residents of the city are concerned for the safety and well-being of their families and children.

Local mental health agencies such as Agency X (the real name of the agency has been de-identified for confidentiality) are available to help victims of community violence. Agency X

provides treatment for children experiencing behavioral health challenges and psychosocial

traumas. Clinicians and managers who work at the agency help to treat client's emotional and

behavioral issues, and any trauma-like symptoms in response to a traumatic event by providing

trauma-focused treatment through evidence based practices and traditional psychotherapy.

Salzinger, Rosario, Fledman, & Ng-Mak, (2008) proposed that

> clinicians targeting the child or adolescents' behavior alone is ecologically short-sighted
>
> because it fails to address how to effect change in the various contexts in which such
>
> behavior is reinforced or how to bring to bear the requisite family or community
>
> resources that might help alleviate the problem. (p.1021)

This theory suggests the idea that clinicians such as those working at Agency X must

integrate micro *and* mezzo/macro level social work practices into their job responsibilities in

order to target the underlying continuity of youth exposure to community violence in cities like

Hartford.

> Without community knowledge and skill, social workers are limited in their ability to
>
> understand and assist clients in shaping and managing the major forces that affect their
>
> lives and help clients empower themselves to develop and manage personal and social
>
> resources. (Hardcastle, 2011, p.6)

The purpose of this research study is to examine what clinicians and managers at Agency

X are doing to integrate an effective collaboration between micro and mezzo/macro level

interventions in order to help youth client's residing in Hartford build *competent communities.*

Fellin, (as cited in Hardcastle, 2011) defined a competent community as "one that has the ability

to respond to the wide range of member needs and solve its problems and challenges of daily

living" (p.96). For clinical social workers working at the micro-level, it is often the case that

mezzo or macro level social work becomes less of a focus in clinical practice; but "it is important for social workers to remember the profession's ecological model emphasis on person-in-environment, which places communities as objects of social work intervention as much as individuals, families, and groups" (Hardcastle, 2011, p.92). After all, "one's self concept, at least in part, is developed through involvement in and identification with social and community groups" (p.5).

This research highlights clinical strategies that are being used and strategies that may be needed in order to better advocate for the youth receiving services at Agency X for the enhancement of their well-being. This study is important to the field of social work as its findings may provide useful information for Agency X and for future research and new practice guidelines for clinicians and administrators. The skills that are being used by clinicians and managers to understand the source of community violence, the exploration of clinicians' and managers' thoughts and insights specific to their roles within the agency, and suggest strategies that may enhance advocacy for Hartford youth exposed to community violence.

CHAPTER II

Literature Review

This literature review focuses primarily on research related to youth exposure to community violence in urban neighborhoods and the detrimental effects it places on youth psychological development. Additionally, research involving clinical strategies used to prevent and/or treat the issue of community violence has been included. The chapter has been divided into four sections. Section one provides a brief overview of statistical data on the prevalence of community violence nationwide and serves as a short introduction to the social constructs driving this issue. Section two addresses more in-depth empirical research detailing the consequences of exposure to community violence. Section three discusses the ideology of a "culture of violence," and section four describes interventions/skills used by professionals to help empower youth and families solve issues of community violence.

A Brief Overview: Statistics and Social Constructs

Youth exposure to community violence has become a leading public health concern in the United States over the past decade, as many studies have shown an increase in child and adolescent exposures and incidents involving violent crimes. The 2009 National Survey of Children's Exposure to Community Violence found that

> more than 60% of the children surveyed were exposed to violence within the past year, either directly or indirectly (i.e., as a witness to a violent act; by learning of a violent act

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against a family member, neighbor, or close friend; or from a threat against their home or

school). (p.1)

More specifically, the study found that

nearly one-half of the children and adolescents surveyed (46.3%) were assaulted at least

once in the past year, and more than 1 in 10 (10.2 %) were injured in an assault; 1 in 4

(24.6 %) were victims of robbery, vandalism, or theft; 1 in 10 (10.2 %) suffered from

child maltreatment (including physical and emotional abuse, neglect, or a family

abduction); and 1 in 16 (6.1 %) were victimized sexually. (p.1)

The National Center for Injury Prevention and Control (Division of Violence Prevention)

reported in 2012 "among 10 to 24 year-olds, homicide is the leading cause of death for African

Americans, and the second leading cause of death for Hispanics" (p.1). A few years before, in

2007, Erika Herrell, author of the Bureau of Justice Statistics' on Black Victims of Violent

Crime found that

Blacks living in urban areas were more likely than those in suburban or rural areas to be

victims of violence; and with that, Blacks in households with lower annual incomes were

at a greater risk of violence than those in households with higher annual incomes. (p.1)

And in 2010, the National Poverty Center (as cited in Santiago-Rivera, Adames, Chavez-Dueñas,

& Benson-Flórez, 2016) confirmed that "poverty continues to be of major concern for many

African Americans, with 38.2% children under the age of 18 living below the poverty line,

compared with 12.4% of European Americans" (p.231).

"Racial segregation exacerbates socioeconomic status disparities by concentrating

poverty and other social problems that are harmful to communities of color" (Santiago-Rivera et

al., 2016, p.233), such as lower levels of academic achievement and housing discrimination

practices that force persons of color to live in economically impoverished neighborhoods. Blacks, Hispanics, and other youth of color residing in urban neighborhoods are undoubtedly subjected to these effects of structural racism which is detrimental to their development, leaving them more vulnerable to the victimization of violence and/or the adaptation of violent/aggressive behaviors.

Additionally, pro-longed exposure to varying types of violence is likely to build cumulative effects on youth well-being. Studies have shown that children who are exposed to the long-term effects of community violence are more susceptible to physical, emotional, and mental harm. For example, a study by Wan-Yi Chen (2010) who conducted a longitudinal study of the relationship between exposure violence in the community and the internalizing behaviors of African American and Asian adolescents found that for

> African American adolescents, exposure to violence in high-crime communities not only poses an immediate threat to their personal safety but also increases their risk of developing emotional distress symptoms. Such negative impact, in turn, could potentially further disrupt their healthy developmental outcomes. (p.408)

Chen concluded her findings by stating "African American adolescents with greater level of exposure to community violence were longitudinally related to subsequent increased level of emotional distress" (p.408).

With both empirical and statistical evidence to support the concerning reality that urban youth are exposed to increasing rates of community violence and poverty, mental health professionals must respond in a carefully planned way, bearing in mind the physical and psychological consequences youth experience in response to community violence.

Consequences of Exposure to Community Violence

For inner-city youth, growing up in violent neighborhoods in cities like Hartford can "evoke stressful responses with physical, psychological, and social consequences, placing youth at high risk for future victimization and injury, and interfering with healthy development" (Teitelman, McDonald, Wiebe, Thomas, Guerra, Kassam-Adams, & Richmond, 2010, p.875). "Even if they are not physically present, children may still be affected by intentional harm done by another (for example, the murder of or an assault on a family member or close neighbor)" (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009, p.2). "Children and youth may experience what are called 'primary effects' of community violence, which include anxiety, depression, or PTSD symptoms, which can then cause 'secondary reactions,' disrupting children's progress on through age-appropriate developmental tasks" (Margolin & Gordis, 2000, p.449).

Margolin (as cited in Margolin & Gordis, 2000) said that "the home and neighborhood, generally considered the primary safe havens for the child, lose the protective and comforting qualities in the aftermath of neighborhood violence" (p.449). A parent's exposure to community violence may cause adverse reactions which effects their own mental health and parenting style, which in turn, effects the youth. The "parents' caretaking can be negatively affected by their own feelings of helplessness, fear, and grief; and efforts to protect the child may be exhibited in authoritarian and restrictive parenting practices, as well as in certain precautions that may heighten the child's anxiety (Garbarino, 1993, p.109). Additionally, Osofky (as cited in Margolin & Gordis, 2000) argued that "community violence is likely to have negative impact on children's formation of relationships noting that the stress associated with community violence affects mothers' parenting ability and resources and children's capacity to form secure attachments" (p.464).

Previous research on family systems and exposure to violence has identified influential aspects that may serve as risk or protective factors for youth. A study by Deborah Gorman-Smith and Patrick Tolan (1998) sought to find what factors reduce negative outcomes (aggression behaviors and anxiety/depression symptoms) associated with witnessing violence. One of the factors within the family system that was a theme throughout this study was presence of *Family Structure*, which

> refers to the level of organizing and support experienced within the family, as well as the degree to which the family does not hold deviant beliefs (e.g., it's okay to lie to someone if it will keep you out of trouble, it's okay to skip school every once in a while). (p.113)

The researchers found that

> exposure to community violence was significantly related to aggression for youth in families with high levels of Structure… [These] results suggest that even organized families many not be able to buffer the effect of youth exposure to violence on aggression…and even [for] families with low levels of Structure, exposure to violence did not appear to additional deleterious relation to aggression. (p.114)

However, for youth living in the same environment experiencing anxiety and/or depressive symptoms,

> exposure to violence was significantly related to increased symptoms among youth with families reporting low levels of cohesion…[These] results suggest that lack of emotional closeness and support from family is related to depressive symptoms for youth who are exposed to violence in this sample. (p.114)

Based on their findings, the researchers recommended that mental health providers can help youth "feel emotionally connected and supported to their family which may provide a context for

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youths to cope with the emotional impact of having witnessed or been the victim of violence"
(p.114).

Additionally, when youth feel unsafe in their neighborhood, there is an increase in fears
that they are in danger, or that someone may harm them at any time. In order for children to
achieve a sense of safety and comfort within their neighborhood, many youth develop coping
strategies to deal with exposure and the effects of community violence, such as avoidance or,
confrontational behavior, and sometimes they will seek social support (Salzinger et al., 2008, p.
1009). Teitelman et al. (2010) investigated inner-city youth's strategies for staying safe in violent
communities. Participants of the study reported they constantly surveilled their neighborhoods
for safe and unsafe places, maintained positive interactions with supportive adults, and utilized
their neighborhood's resources, such as recreation centers or afterschool programs, as ways to
maintain safety. Participants also reported strategies they use for coping with interpersonal
violence from members of their community when threaten by it. These strategies included
confronting and/or fighting back, or ignoring a situation/walking away (Teitelman et al., 2010).
Salzinger et al. (2008) who studied youths' aggressive behavior as one of the adaptive responses
to violence exposure, found that children who adopt confrontational behavior as a strategy to
avoid being victimized is a way for them to literally survive in their environment, but which
ultimately maintains the cyclical nature of aggressive behavior and violence within a community.

No matter which combination of coping strategies children and adolescents use, young
survivors and witnesses of community violence still potentially "suffer serious psychological
consequences including posttraumatic stress disorder (PTSD), increased risk for depression,
cognitive and academic delays, and increased aggression" (Guterman & Cameron, 1997, p.496).
Community-based mental health workers may help youth and families to realize their

psychological and physiological symptoms as reactions to these traumatic events. Moreover, it may also help youth and families to reflect on their own culture's attitudes and beliefs about violence, and those that have been imposed on them.

A Culture of Violence

Research has identified links between exposure to violence and behavioral outcomes in children, yet little attention has been paid to culture. "Culture influences norms, beliefs, and values surrounding the use of violence, expectations and reactions by caretakers to victimized children, and the way children understand and label their own experience (Margolin & Gords, 2000). A briefing written by World Health Organization (2009) on violence prevention education for advocates argued that cultural and social norms are what encourage violence. Cultural acceptance of violence

> persists within society because of individuals' preference to conform to using violence,
> given the expectation that others will also conform, which leads to a variety of external
> and internal pressures that maintain these cultural and social norms…Thus, individuals
> are discouraged from violating norms by the threat of social disapproval or punishment
> and feelings of guilt and shame that result from the internalization of norms. (World
> Health Organization, 2009, p.4)

While this theory does hold value in examining the relational dynamics of peers in social settings, one must also consider the larger society's viewpoint of inner city violence and question how and why society imposes certain stereotypes on communities of color who exhibit violent behaviors. To begin to answer that question, the different levels of racism must be discussed and understood.

The historical and structural racism on people of color has negatively affected

communities in detrimental ways; poverty, housing discrimination, mental health

disparities, community violence, and low levels of educational attainment are some ways

that racism continues to impact communities of color today. (Santiago-Rivera et al.,

2016, p.229)

Racial segregation is often thought of as a historical policy that had been eradicated in the

1960's and is no longer present in modern day America. Yet many people of color continue to

live in hyper-segregated neighborhoods around the country. Hartford, for example, is a perfect

example of this scenario. Compared to the towns surrounding Hartford which are predominately

White, the racial makeup of the city includes 38.7 % Black or African American, 43.4 %

Hispanic or Latino, (of which 33.7 % are of Puerto Rican heritage, and 29.8 % White (U.S.

Census Bureau, 2010).

According to research by the U.S. Department of Housing (as cited in Santiago-Rivera

et al., 2016),

Individuals for whom their racial and or ethnic background is visibly identifiable,

encounter more [housing] discrimination than those who are perceived as

White…specifically, about 12% of Latinos, 11% of African Americans, and 10% of

Asian Americans who contacted agents regarding recently advertised housing units for

rent were shown fewer available units than equally qualified European Americans (p.

232).

Non-white persons also experience less financial assistance as prospective homebuyers, making

it more difficult for anyone in this situation to potentially move out of their neighborhood, if they

would chose to do so. "These housing practices lead to segregated neighborhoods and

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consequently contribute to inequalities in access to transportation, employment, and quality of health care and education" (Santiago-Rivera et al., 2016, p.232).

As residents become "trapped" in their neighborhoods, this further diminishes their access to employment opportunities, which results to an impoverished community. "Because fewer jobs are available in these areas, residents turn to secondary and illegal job markets for employment (outside of the mainstream and the law), and crime rises" (Miller & Garran, 2010, p.67). As crimes rates rise, people begin to feel less safe in their community and as such, stay isolated within their home or immediate neighborhood.

As residents become more socially isolated, fueled by the absence of adequate transportation, well-paying mainstream jobs, and increasing crime rates, there are fewer role models for prosocial behaviors, which leads to a climate where self-destructive subcultures can evolve, including the rise of gang activity. (Miller & Garran, 2010, p.67).

With crime rates rising and gang related activity taking place, law enforcements begins to increase patrol in these communities. Police officers "often feel threatened, alienated, and prone to overreaction, which contributes to an escalating cycle of tensions between residents and authorities" (Miller & Garran, 2010, p.67), leading to higher rates of incarceration (compared to low-income European American communities). Parham, Ajamu, and White, (as cited in Santiago-Rivera et al., 2016) concluded that "the racial disparity in incarceration rates leads to the unfortunate breakdown of families, thus negatively impacting the stability of such communities" (p.234).

The idea that violence is a normative part of someone's culture or race is a socially constructed stereotype that maintains the cycle of racial segregation, and residential isolation between White and non-white folks. There are harmful effects of structural and institutional

racism. Without discussing these issues, White folk will likely continue to hold stereotypes about communities of color that are unchallenged by reality. People of color who may be less empowered against the larger effects of structural racism may continue to adapt the idea of community violence as a cultural norm without questioning the larger forces at play.

Clinical Strategies used in Response to Community Violence

An article published by Irene Rodriguez Martin published in 2010 described her study of the development and construction of a community response to violence. Martin highlighted the role of social workers using interdisciplinary outreach skills to intervene and empower local community members to help get their needs meet. Martin listed several key factors in

> developing and sustaining a partnership to guide a community response to violence:
> First, it is essential to acknowledge community leadership and to solicit participation
> from leaders and other community stakeholders at multiple levels. Once convened, this
> group needs to be empowered to define and to take leadership in shaping the community
> response. In identifying stakeholders it is important to consider not only different
> disciplines represented in the community, but also the diversity of the community. (p.
> 354)

Developing a coalition requires social workers of all disciplines to dismantle the hierarchy of power and build partnerships with community members who share the same purpose of protecting children and families while bringing an end to community violence.

Martin (2010) expressed the belief that "partnerships are sustained by pulling various entities together to define common goals, determining what each entity would do to support those goals, and design and implement specific interventions" (p. 350). These are the strategies clinical psychologists Martin La Roche and John Tawa (2011) used to design their three-stage

empowerment model to help Black and Latino youth residing in Boston foster peace promotion through community action in response to community violence. The psychologists' primary objective for this model was to gain an understanding of the youth's subjective experiences in order to "attend to their symptoms as they are embedded within specific sociocultural contexts" (p.4), and empower these youth to promote individual and contextual change. "Clinical treatment models frequently disregard the voices of the youths themselves, perceiving them as incapable of understanding their own clinical needs" (p. 6), which further pathologizes youth's symptoms and maintains social injustices. Instead, La Roche and Tawa sought to "privilege youth's perspectives of their problems" (p.9), and normalize youths' response to traumatic community violence through understanding the contextual embeddedness of their symptoms.

According to La Roche and Tawa, after youth's problems have been assessed, the next step is to explore youth narratives. "The main therapeutic goal during the second stage of this empowerment model is to explore and acknowledge the different dimensions of adolescents' experiences, including their understanding of their symptoms, as well as their experiences of social injustices" (p.12). Youth were prompted by the authors to consider their complex social identities as they are formed within different institutional and community settings. "Social expectations from peers, teachers, and society at large may inadvertently pressure Black and Latino youths to internalize and act-out social roles of violence and aggression. Thus it is important for the group leader to explore stereotypes of youth of color and how they operate to constrain their emotional and identity options" (p. 13).

It is from this understanding that youth are able to explore and construct their identities separate from racial stereotypes, which empowers them to challenge the source of their struggles by demanding social action for social justice. This leads to stage three, where "putting into action

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an awakened social consciousness gradually leads to a desire to transform and improve oneself

and one's context" (La Roche & Tawa, 2011, p. 16). Youth realize they do have a voice and

begin to promote social change. They become motivated by a desire to help those in their

community who are also suffering similar tyrannies. "Rather than blaming members of their

community for the widespread poverty and violence, the youths increasingly develop a critique

of the social structure, including its lack of response to community violence" (La Roche & Tawa,

2011, p. 16). Community members come together to make peace within their community, and

channel their feelings of anger and despair towards working together to combat racism. Yet with

a legacy of oppression against communities of color in America, fostering social change can feel

defeating without support from leaders from within that specific community and support from

dominant-culture activists. Therefore La Roche and Tawa strongly suggest when working

> with marginalized groups, therapists cannot assume a neutral psychotherapeutic stance
>
> regarding issues of structural violence, racism, and oppression. They need to make clear
>
> their position against the oppression experienced by persons of color – maintaining a
>
> bystander position can be equated with siding with injustice. (p. 14)

So, clinicians who work in micro level social work settings should incorporate

mezzo/macro skills into their practice, as they are an important part of a comprehensive approach

to the development, implementation, and evaluation of clinical treatment with individuals,

especially when the issue is community related. Together, multiple individuals from the

community and mental health agency can work towards accomplishing systems change.

"Formalized systems coordination is especially critical for youth violence prevention and

treatment, as this issue suffers from the "many homes" and "no home" syndromes, i.e., the

responsibility to address youth violence is typically fragmented across agencies or falls through

the cracks between them" (Sugimoto-Matsuda & Braun, 2014, p.195). "Thus, abstract domains of micro, mezzo and macro social work practice remain; and as a result, many violence prevention and treatment efforts focus on the individual and his/her immediate relationships, and macro-level interventions are less-often attempted" (Sugimoto-Matsuda & Braun, 2014, p. 195).

Theoretical Orientation Underlying This Study

The aim of this study then, is to gather ideas from clinicians and managers at Agency X on how to address issues of community violence as mental health professionals in a community-based setting. As Hardcastle (2004) suggested, it is often the case that micro level clinicians and managers in community-based agencies focus on individual behaviors of the child/adolescent, with little to no discussion with youth individually about the communities from which these issues arise. In order to create physiological and behavioral change, micro level clinicians and managers should also be thinking critically about "the bigger picture" – the person-in-environment. Though this objective may feel outside of the micro level clinician's role, it is not, because in order to provide holistic care to all clients, we must consider a client's age, gender, race, ethnicity, socioeconomic status, etcetera as these identities intersect with the environment with which they live and the politics that govern their lives. "[All forms of] racism causes people to feel disrespected, unwanted, and wary of the motives of others – it can cause feelings of powerlessness" (Miller and Garran, 2010, p.184). So as La Roche and Tawa (2011) suggested, micro level clinicians and managers who in their professional lives, at least, are a part of the oppressive and racialized systems/organizations must work systemically to empower youth towards preventing violence in Hartford.

This study took place in Hartford, Connecticut because it is an optimal city in which to access participants (clinicians and managers) working with inner-city youth. As was briefly

mentioned in the introduction, Hartford's community is characterized by poverty and varying types of violence. This study seeks to address the following six questions in regards to how clinicians and managers are incorporating micro and mezzo/macro level social work practices to help Hartford's youth exposure to community violence:

1. Do participants get a sense that clients at the Enhanced Care Clinic have been traumatized by community violence? If so, how big of a problem is it and how is conversation initiated with a client about their victimization and possible traumatization of community violence?

2. How do participants understand the source of community violence in Hartford?

3. How do participants think the agency thinks about community violence?

4. How do participants advocate for youth victims of community violence?

5. What do participants see as their role within the agency in combating community violence?

6. Have participants received any preparation to assess or treat the problem of community violence in their professional education?

CHAPTER III

Methodology

The purpose of this study is to gather a greater understanding of clinical perspectives amongst clinicians and managers at Agency X regarding the implications of community violence in Hartford for the agency's clients. This study will specifically explore how their perspectives may influence clinical interventions used during sessions with clients as well as what they perceive their role to be in addressing a community wide issue. Given the increased rate of community violence in Hartford during the past year, this research study is especially important because the majority of clients and families receiving services at the Enhanced Care Clinic reside in Hartford and may have been traumatized by these occurrences.

This research study offers the opportunity to bring together clinicians and managers to think critically about and discuss the complexities of community violence in Hartford, in order to better serve children and families. Agency X clinicians and managers participated in focus groups. I determined this method since focus groups allow for a natural flow of conversation between participants about one another's perceptions, ideas, and attitudes, and build on one another's perspectives. In this case, clinicians and managers had the chance to think critically about the complexities of community violence in Hartford, CT and how this issue affects and contributes to clients' behavioral functioning and mental health.

Sample

Participants in this study were full-time (forty hours or more) or part-time clinicians at Agency X, in Hartford, CT and have a master's degree in social work, counseling, art therapy, psychology, or marriage and family therapy, or a PhD in psychology. There were 15 participants in this study, all of whom were required to provide informed consent form prior to engaging in the focus group. Participants were not excluded based on age, sexual orientation, how they identify racially and/or religiously.

Recruitment

Prior to the recruitment of participants, approval for the study and all safeguards to ensure ethical standards were obtained from Agency X Institutional Review Board committee (Appendix E). The attached flyer (Appendix A) was placed in each clinician's and manager's mailbox at the agency. The flyer was also emailed to all Enhanced Care Clinicians' agency email address. Clinicians were asked to contact me in person or by email. Once eligibility for the study was determined, I provided two copies of the informed consent letter (Appendix B), one of which the participant signed and returned to me in person or via interoffice mail, the other copy was for the participant to keep. Extra copies of the Consent form were brought to the focus group in case participants had not sent their copy to me prior to the focus group session.

Data Collection

Agency X is located at two locations in Hartford, CT, in order to bring services to the neighborhoods of families served in their geographical location. As a result, clinicians are divided between the two locations, so there were two scheduled focus groups at each location. Participants were able to choose which of the two focus groups they would like to attend. Agency clinicians were prompted with a number of questions put before the focus group to

facilitate discussion about what they perceive to be the source of community violence in Hartford, the prevalence and frequency at which the topic of community violence is discussed during sessions with clients and within their role as a clinician/manager (see attached Interview Guide, Appendix C). Focus groups were held at the agency during the work day lunch hour. Each participant received pizza for lunch following their participation. This compensated the clinicians and managers for their time and participation in the study. I met with each focus group once. Focus group sessions lasted approximately 30- 60 minutes (due to the varying quality and length of discussion) and were audio recorded for the entire length of the focus group. Participant responses were recorded using my personal tablet device. Audio recordings are stored on the tablet and my personal laptop (for back-up purposes), and those files are password-protected. Transcriptions are also stored on my personal laptop and are password protected, and signed consent forms are stored separately in a secure locked cabinet.

Ethics and Safeguards

Protection of Privacy

Information obtained from participation in this study was revealed in aggregate form and/or by individual examples, but not in a way that the individual participants could be identified. For example, direct quotes from clinicians are included in the data analysis section of this paper but the person's name and other personal information was kept confidential. However, since data were collected in focus group format, confidentiality could not be assured because participants are aware of who else participated in the study and what information they provided. I asked all participants to keep this knowledge confidential, but ultimately am not able to prevent participants from revealing information outside of the focus groups. Additionally, even though responses are disguised, participants were drawn from a relatively small pool, so it is impossible

to disguise responses sufficiently to assure a non-participating agency employee won't be able to guess participant's identities should they read this final report.

Risks and Benefits of Participation

The possible benefits from participation in this study include the enrichment of each clinician's professional practice as an employee with Agency X. Participants were able to reflect on their own perspectives regarding the source of community violence in Hartford, as well as what they believe the agency's perspective is. It is my hope that this study may influence a clinician's approach to providing clinical services as they consider what their role is as a clinician in a multifaceted approach to addressing a community wide issue. Sharing their thoughts during the focus group helped clinicians and managers assess and reevaluate the needs and resources children, adolescents and families need.

Results of the study are available to Agency X administrative staff and clinicians upon request. Administrative staff may benefit from the information found in the study. This study may encourage professional clinicians and/or community mental health agencies to evaluate their clinical effectiveness and gather new possible interventions for youth and community in addressing issues of community violence. Clinicians who participated in this study have made a contribution to the field of social work research as a new source of data. There are very few research studies that focus on clinicians' (employed at a community mental health agency) clinical skill set which can be used to engage urban youth who have witnessed or were victims of community violence in clinically creative ways.

There were no anticipated risks involved in this study; however, participants were informed that should they feel any anxiety or distress while participating in this focus group they had the option of choosing to opt out of participation in the focus group at any time. It was

explained that participants may refuse to take part in the study at any time without it affecting their relationship with the researcher of this study or their employment. Participants were informed they had the right to not participate in the discussion of any single question, or even to leave the group before the end. But, because of the group format, participants were informed that if they chose to withdraw during the focus group, any conversation material or information they provided could not be removed from the transcript and may be a part of the final report.

Data Analysis

Agency X clinicians and managers interested in participating in the study completed a short demographic questionnaire (Appendix D) before the focus group. Demographic questions included: participant's name, gender, ethnicity, years of clinical experience, number of years employed at Agency X, and their academic discipline. Also, participants were asked to answer "yes, no, or somewhat" in response to whether or not they have received any preparation to assess or treat the problem of community violence in their professional education.

Recorded responses were transcribed by me. Data analysis was completed by observing patterns and/or themes in responses from participants, leading to a theoretical orientation reflective of participants' clinical thoughts and practice. In my analysis I looked for barriers as to why clinicians and/or managers may not be able to incorporate mezzo/macro clinical practices in their individual work with clients as suggested as best practice in the literature review. Analysis also looked for hieratical disparities amongst clinicians and managers based on their responses to questions and implementation of practice skills. Findings will include comparison of answers amongst all focus groups, with special attention to population served based on demographic location between campuses, as well as responses between clinicians and manager focus groups. Findings will also be compared to the literature reviewed in this study.

CHAPTER IV

Findings

This chapter presents findings from three focus groups; a total of fifteen racially and experientially diverse clinicians and managers from Agency X in Hartford, Connecticut in February and March 2016. The interview questions were designed to reveal clinicians' and managers' opinions on the subject of community violence in Hartford and to share clinical skills used to address said issues through the use of focus group discussion.

The data collected consisted of eight specific thematic sections: 1) demographic data about each participant, 2) the prevalence of community violence in Hartford, 3) participants' understanding of the source of community violence, 4) how participants address the topic of community violence with youth, 5) why there is a normalization of community violence, 6) how clinicians and managers are providing support, 7) clinicians suggestive feedback about how the agency may better improve their response to supporting clients, and 8) a synopses of participants' formal education in preparation for treatment of community violence.

Initially, two focus groups were planned to include managers and clinicians at the clinic. However, some managers conveyed hesitation and felt uncomfortable joining a focus group with clinicians because of their leadership position, taking in to consideration the power dynamic associated with their professional relationships with clinicians. Managers were worried that their presence in a focus group might influence a clinician's response to a question. Managers did not attend either of the two focus groups, but voiced their interest in wanting to participate in the

study. As a result, I held a third impromptu focus group for managers only. Managers were asked the same set of interview questions as clinicians and were also required to complete a demographics questionnaire.

Demographic Data of Participants

Focus group A consisted of two managers, Focus group B consisted of nine clinicians, and Focus group C consisted of four clinicians; a sample size of 15 participants in total. Focus group A had one manager who reported having nine years of clinical experience with her master's degree in social work; and the other manager reported ten years of experience under the same degree. Both of these participants, who identified as white females, have been employed approximately eight years at Agency X at the time of this study.

Participants in Focus group B were more diverse in their years of clinical work experience, degrees and ethnic backgrounds. The least amount of clinical work experience reported in this group was two years, and the most being sixteen years. There was one art therapist, one marriage and family therapist, six social workers, and one who labeled her academic discipline as clinical psychology. All participants in Focus group B identified as female; there were five White females, two Black females, one Asian female and one Latina. There was also quite a range in Focus group B duration of employment at Agency X; which included one week to more than twenty years.

In Focus group C, all participants identified as white females. There were two art therapists, one social worker, and one marriage and family therapist. The clinician with the least amount of clinician experience reported two and a half years, and the most being nine years. Their duration in employment at Agency X ranged from four months, to three years. Out of the entire sample, only two participants reported they received preparation in their professional

education to assess and/or treat the problem of community violence. Six participants said they did not receive any preparation in their professional education to assess and/or treat the problem of community violence, and seven participants said they felt somewhat prepared.

The Prevalence of Community Violence in Hartford

All fifteen participants agreed that clients at the Enhanced Care Clinic have been traumatized by community violence. When asked how big of an issue they believe it to be, a participant from focus group A said that "over half of clients" have been affected by community violence; a participant from focus group B believes that it is "90%, if not 100%, of clients," and a participant from focus group C stated "at least 75%" of clients have been affected by some type of community violence. There was a general consensus among all focus group members that community violence in Hartford is a widespread issue, and a few clinicians likened the interconnectedness of clients, families and community violence as a "web."

What is the Source of Community Violence?

Clinicians and managers were asked to share their thoughts and opinions about what they believe to be the source or sources of community violence. All three focus groups provided similar answers, which were organized into 9 major subthemes: (a) intergenerational violence, (b) mixed messages about violence from caregivers, (c) peer pressure from social groups, (d) youth upholding their social reputation, (e) gang-related activity, (f) low economic status, (g) lack of opportunities/resources, (h) drug use and involvement, and (i) institutional oppression.

Intergenerational violence

Intergenerational violence transmitted from parents/caregivers to children was highlighted as a source of community violence. Intergenerational violence was defined (by the researcher) as witnessing domestic violence between adults and/or the use of physical

punishment at the hands of the adult directed toward the youth. Clinicians undoubtedly linked youth's aggressive behaviors to witnessing and victimization of intergenerational violence. A clinician from focus group C said,

> If they know anything about how their parents have handled situations with aggression…I think they sometimes model what they were raised with. If they see someone do it, they are more apt to follow what they are doing. Also, domestic violence…seeing that, and then not being afraid to hit when something goes wrong. It's also the physical abuse the kids endured. This all plays a factor. It's the way you were brought up is what is ingrained; it's what you were taught.

Related to this topic, a clinician from focus group B stated, "They learn from modeling and that could be keeping the cycle going."

Mixed messages about violence from caregivers

Clinicians also believe that the "acceptance" of this behavior is what maintains the cycle of violence. For example, one clinician commented that during more than one family therapy session, she has witnessed parents say to a child, "oh, they swung first? Yeah, you're right; you should have defended yourself – regardless of the situation." Other clinicians agreed they remember hearing statements like this during sessions. This apparently appears to make clinicians feel frustrated when trying to help youth reduce their aggressive behaviors. The frustration stemming from the "mixed messages" clinicians and youth receive. A clinician summarized the struggle of this work:

> I think there is a lot of ambivalence in a lot of our parents in that, on one hand they'll say "I don't want my kids to be in trouble and they keep getting suspended and this is really frustrating," but then also send this mixed message of like "well if someone hits you, you

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better hit them back." So from parents and even grandparents, because it's often also grandparents raising the kids, there's this 'I want you to hit back so long as you don't get caught, like only to a certain degree.' But the kids aren't going to get that. There are like these lines drawn in the sand that don't exist in real life and you can't have it both ways. Another clinician followed this statement by saying, "Right, like you can't just throw one punch and expect the kid to stop. Once you're in it you're in it."

Peer pressure from social groups

The expectation to fight back extends beyond what messages youth may receive from caregivers to peers as well. The consideration of social group values and morals which drive the standard attitudes and behaviors of that group was mentioned during discussion in each focus group. One clinician said,

I think part of what fuels community violence is the sort of values that drive these kids' social groups and social media. Things like kids' getting filmed fighting which then gives them sort of like a reputation of being tough.

She went on to say that in her experience of working with inner-city youth, they are often caught up in the idea of upholding their reputation of

Who's a punk, who's not a punk, whose tough, who won this fight, who won that fight and it just seems hard to figure out what avenues to motivate kids to look beyond that. Maybe help them find a role model who doesn't do those things…and deals with their problems without getting into a fight, but a lot of their role models are...young white ladies who are their teachers or their therapist so they don't have someone who's had the same life experience they've had.

Another clinician nodded in agreement with this statement saying, "They think that 'oh wow I'm in Hartford, this stuff is bad, I'm supposed to be big, and bad, and strong and it's not supposed to bother me.' The first clinician then replied,

I feel like that whole piece, like being big and bad, not being a punk, is such a huge part of the lower levels of community violence with like the fighting aspect of it - so not like lethal violence in terms of guns and shootings but the number of like fights of kids get into in school.

Gang-related activity

Related to the topic of peer pressure from social groups, clinicians and managers listed gang related activity as another source of community violence. One clinician elaborated by stating

hanging around certain peers that handle things a certain way, you want to be liked by them so feeling that peer pressure to do that I guess it's almost parallel to the gang thing. If you want to be in this gang then you have to do X, Y, and Z to be part of us. Some kids are just looking for that close-knit family because of their disruption in their relationships with their parents. They are going to seek it out somewhere and if they somehow get into a gang, they end up making poor choices, thinking that that is acceptable and people are going to accept me.

There was a clinician who actually confirmed that gang related violence was a true source of the community violence happening in Hartford. She said, "There was a time where Hartford police couldn't deal with it and there were many, many gang members that were incarcerated but what they are saying now is that many of them are getting released and they are back."

Low economic status; lack of opportunities/resources

A few participants mentioned low economic status as a source of community violence as well, particularly in regards to families not having the funds to involve their children in prosocial activities such as afterschool programs. One clinician commented, "I think it also goes into economic status. Do they have enough money to get into extra circular activities? Do they have the money to go to after school programs and things like that?" Likewise, a manager shared her thoughts, stating

> I think that poverty plays a role – lack of opportunity, lack of resources. So, if there are
> not good jobs for people to obtain and even for kids to aspire to, then they are more likely
> to get caught up in what might be going on in their street or their neighborhood.

She also went on to talk about drug use and drug related violence as a possible source of community violence. "I think drugs also actually play a factor in that as well. So like drug related violence and again it kind of has to do with lack of resources, lack of opportunity that kind of thing."

Drug use and involvement

Like this manager, many clinicians from focus group B and C agreed that drug involvement does contribute to the violence in Hartford. Some clinicians pointed out that for many adults and youth the selling of drugs is a means for financially providing for their families, especially those who are living in poverty and are disconnected from financial or prosocial opportunities. A clinician from focus group B stated,

> I always think it's so much harder to go into like Dunkin Donuts to work 8 hours to make
> this small paycheck versus like selling drugs; and if you're trying to provide a house for

your child - not that it's a safe choice - but it just feels like the only choice. Sometimes

people just have to survive.

In agreement with this comment, another clinician replied, "I think there are a lot of broken

families in Hartford. Like you're saying, for a single mom, is it easier to do an 8 hour shift or sell

drugs?"

Institutional oppression

Exposure to all of the above is the unfortunate truth of many inner-city youth and

families who have lived their lives in peril due to racism, capitalism, and institutional oppression.

These political and discriminatory beliefs have limited people of color and poor people of any

color for many years; and in order to gain social and economic capital, youth are sometimes left

with no other option than to partake in criminal-like behaviors in order to survive, as one

clinician commented:

My perspective is that this is such a deep seated issue that comes from a lot of history in

this country and it just feels unsolvable in some ways. I always think about the black

community, but I know this year it's been a lot of the Hispanic community that has been

sort of at the center of the violence, but I think about slavery how slaves did not own

property so all the white people had the property and so it's like they had a leg up from

the get-go and poverty drives this situation a lot of ways. So you're in this community,

you see that the people who maybe are selling drugs are in gangs and are the people that

have the nice cars, and are the people that have the access to different things. I feel like

it's just hard to kind of escape. It's sort of this cycle that has been created.

Adding to this statement, another clinician gave a brief but very real summary of the ways in which all these complex factors contribute to this deep rooted issue and the history of institutional oppression at the intersection of family and cultural values.

> Sometimes it's just family belief – my father did this, so did my grandfather, so I'm going to do this because that's just the way of life. This is how we do things around here. We sell drugs. That's how we make money. We shoot people because that's what they do when they disrespect us – it's about disrespect or how do you earn respect. They think "oh, we have to be tough, we have to retaliate it" so, it's such a deep rooted issue. How do you get out of it? How do you even help them to get out?

How is the Topic of Community Violence Discussed with Youth?

When asked how clinicians and managers initiate a conversation about community violence with clients, participants across all three focus groups agreed that discussion stems from information recorded in the initial intake assessment. Clinicians are required to complete an intake assessment once the client agrees to outpatient services. This assessment includes a trauma screen which evaluates for all types of trauma and includes questions that allude to possible witnessing of and/or victimization of community violence. Clinicians and mangers review the intake assessment and trauma screen before meeting the client and are informed of any possible community violence this way. Clinicians from focus group B and C said they use the first session or two to discuss incidents that may have impacted the clients and family, and how greatly they were impacted by such events.

Though all clinicians and managers reported utilizing the intake assessment to discuss incidents of community violence with their clients, there were some differences as to whether or not clinicians initiate conversation about community violence aside from what information was

noted on the intake assessment. It seems as though clinicians are most likely to initiate the topic of community violence at any time during treatment when: 1) there was an incident that recently happened within the community and it has been broadcasted via public news or interoffice mail and/or 2) the client is experiencing trauma symptoms (or trauma-like symptoms) related to a recent exposure to community violence. One clinician from focus group C stated:

> I feel like the times when I talk about [community violence] directly it's been in the context of doing a trauma treatment model, in this case TF - CBT, during the psychoeducation part when something came up in the initial screen and I know about it and I'm following up with making sure I'm doing I'm doing the psychoeducation about it - that's the most in-depth conversations I've ended up having about it. Otherwise it usually doesn't get brought up with the exception of a couple times where we had incidents happen right in this area where it was like "don't take that way to the bus, take this way."

Another comment was:

> I have a client who heard gunshots while he was at his grandmother's house and so part of what I'm doing with him is just kind of further assessing how that experience has been impacting him and the way that I approached it is just kind of talking about more about his feelings - he's five, so like feelings identification, and just allowing him to talk about it...I'm going to do further screens and further assessments but that's just kind of where we are starting – but it's not his "norm," so that's another piece as to it why it gets brought up so much.

A clinician from focus group B shared that she makes sure to follow the news to keep herself informed with what is going on in the Hartford community. She stressed that this is especially important as a white, female clinician who lives in the suburbs. She said,

> I try to stay educated and informed about what's going on so I can be ready to have those conversations and not seem like I'm just this privileged white person who doesn't have to deal with it. I get to drive home and go to my safe place and you know I don't have to deal with it so I just think it's important for them to feel like: "you care; you're thinking about me even when you're not with me."

Similarly, managers reported that they make sure to address an incident of community violence during sessions, but also sometimes wait for the family to initiate conversation instead. One manager reported, "If there is a particularly significant event in the community sometimes I will bring it up to them and say: 'Is this something you would like to discuss? Are you affected by it?' Another participant added, "I would say more often than not the family is bringing in the information and bringing it up in session, but there have also been times that I have brought it up to them." Apart from family members starting the conversation, managers have also received phone calls from the school liaison and staff of other agencies who are interested in collaborating with the Agency X to help support youth and families following a traumatic incident. A manager said,

> We get calls from the high schools or from the community saying: "there was a shooting here last night and people want to talk about it; what can you guys do for us...how can we bridge services for this family..." Or, "can you come to the school to help facilitate a discussion with students?"

Clinicians, like managers, have experienced occasions where clients raised the issue during session. In cases where clients raised the topic of community violence, clinicians reported it was most likely after a major incident happened in the community, or following a personal attack on a youth's family member. For example, one clinician from focus group B reported, "I had a client who saw a family member get stabbed and they had to come in for a crisis session." However, clinicians from focus group C reported initiative to address issues of community violence less often comes from a client. From the group C clinicians' perspectives, it is mostly the caregivers who initiate the conversation around issues of community violence. One clinician from this group stated:

> A lot of times kids and teens don't necessarily bring it up. The teens will bring it up a little bit more but it's the parents who bring it up because I've had situations where the child is really aggravated with the parents because they won't let them go play basketball after school and when I follow up with the parent she says "yeah, I can't be sure that he's safe and I don't have a way to make sure he's OK."

Another clinician from this group agreed, stating:

> I think parents probably address it a little more, but privately and in a way that is just kind of acknowledging why they have their child do so many afterschool programs; because "they are better off at the school and I know where they are" versus, even being home and what they might be exposed to in the neighborhood.

Clinicians from this group theorized why youth might not want to discuss a recent incident that happened in their community. As a group, they guessed that youth might think "it's not going to change by talking about it – there's still going to be violence so they're just like 'why talk about it if it's something that's going to be ongoing?' Another clinician from this focus

group said, "Maybe kids or teenagers are not talking about it as kind of like a resiliency thing, like, "I want to feel safe where I where I live, and in my community."" Another theory was that clients may be worried about the information being shared in session being brought back to the community. Yet the one theory that all clinicians, in all focus groups, appeared to agree on was the normalization of community violence as a reason why issues of community violence are often less talked about by youth. One clinician seemed to capture it seamlessly when she said, "I think [community violence] is under-reported because it's so normalized."

The Normalization of Community Violence

The idea that community violence in Hartford is a normal occurrence for youth and families was a unanimous agreement across all three focus groups. As the literature suggests, the social norms a community creates around the notion of community violence is what either encourages or discourages the use of violence. One clinician shared her experience with a couple of clients who lived in a town outside of Hartford and then moved into the community. She summarized one client's description of their assimilation to Hartford:

> When I first start seeing them, they're like "oh yeah I hear gunshots and it's really scary," when they've just moved to the area; and then 6 months later it's like "oh yeah I hear that all the time;" and it just becomes normalized to hear gun shots or see fighting in the street.

I found that there was normalization, perhaps even anticipation from the clinicians that residents within this neighborhood will use community violence to solve their problems. One clinician from focus group B said, "We actually have clients say: that's normal, that's just – it doesn't really bother us. We know its gun shots but it is what it is." Another clinician added to this statement, saying

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I had a client who witnessed her mother stabbing another woman in the front yard and as she described it to me she was just like "yeah, I saw my mom stab her and the lady kind of deserved it." I found myself wanting to prod because I was like, oh this *had* to have traumatized you, but no, I think she was very resilient and I also think a piece of it was that maybe that was not so uncommon with other experiences she had. So, it might just be a normal day in the life.

Clinicians emphasized resiliency and normalcy as reasons why clients may not bring up the topic of community violence during sessions. A clinician from focus group C said,

I think clients tend not to bring it up, if I had to guess why maybe because it's so normal and then if I don't bring it up it's usually because there's either something else we're focusing on, or other things are more pressing at that time.

Another clinician from this focus group added, "Yeah, if they don't bring it up it tends to fly under the radar. I think partly because it's so normal but it's not something that necessarily gets talked about."

Managers also spoke about the community's normalization of violence. One manager commented,

There is a normalization of violence. There might have been something that a client experienced in their day to day life that they're not realizing might have been a trauma for them. So, they might not bring it up in session.

Because of this, both managers agreed that clinicians should be conducting ongoing assessments to "check-in" with client's about any violent experiences they may have witnessed or been victim to. Expanding on this comment, a manager shared,

I was thinking similarly, if a client is avoidant, or maybe it's not even avoidance, but maybe they're just not talking about it, having to facilitate the conversation and working through maybe the staff's own resistance or avoidance is relevant to treatment and symptoms reduction.

A few clinicians reported their own feelings of resistance around discussing violence. For example, one clinician who was witness to a violent shooting said

This incident impacted me greatly…because I was affected by it and I could not be there for these people because I witnessed this happen and all this crazy stuff. So, the agency was really great about honoring my needs. The managers were able to say "okay, these people are going to go to another clinician."

In further discussion regarding how clinicians may have experienced or dealt with resistance and/or avoidance, a clinician responded,

I think the challenge is like trying to maintain your clinical presentation in front of your clients that are bringing stuff like that – it's so shocking, it's so outside of what so many of us experience in our regular daily lives. You have to maintain your clinical manner but then as soon as they leave you're like "what just happened?!" So, I think that it's hard – that balance. I think it's hard to find the middle between making sure you're supporting them and that you're reacting in a way that appropriate but also making sure you attend to whatever you need to attend to after hearing things like that.

How Clinicians and Managers Provide Support

With complex issues of client trauma, clinicians' countertransference, and a systemic normalization of community violence within the Hartford community, what role do enhanced

care clinic managers and clinicians play in all of this? How do they support their clients on a micro, mezzo and macro level? Speaking to mezzo level interventions, one manager said,

> I feel like there's probably things I'm not aware of regarding partnering with agencies or that kind of thing, but we've had the brown bag luncheons to talk about Ferguson, MI and what was going on there; and then when there was a peak [of violence] in Hartford, there were drop-in discussions about what's the impact, how do we support you, how do support your clients, so I feel like it's – I feel like there's good stuff, there's good response out there.

Another clinician followed this comment by saying, "the agency is always looking at ways of how we are going to act when there are significant community violence situations that happen." Agency X managers shared specific outreach work managers and upper management staff has organized in the past:

> After there was a shooting in a grandparent housing community they called us and wanted us to go there…and other agencies went…but they wanted a forum …they wanted support with, like, how do we prevent this from being "normal?" How do we talk to the kids about the reality but not in a way that is going to freak them out or trigger them or that kind of stuff?

So on a mezzo level, it appears that managers are certainly helping to respond in times of crisis, and have been partnering with other agencies to strengthen their commitment to the Hartford community. They are the first point-of-contact to help organize outreach work in supporting clients, families, and clinicians in the aftermath of an incident involving community violence. The managers did agree that at this point the focus for addressing issues of community violence on a mezzo level is on "responding generally, and [thinking] about ways to further

address this more from like a place of support. A participant followed this up by saying, "I don't necessarily know if it's on the agenda around, like, prevention of future community violence."

On a micro level, managers not only act as a liaison between the clinic and community members, but their position also entails supporting clinicians in their work of addressing community violence issues during sessions as well as supporting their own caseload of clients and families who are involved in community violence. When working with youth, managers often think of safety planning as an important place to intervene. One manager said,

Safety planning and making sure that the client feels safe no matter what the setting is. If you're in school, how can we work with the school to make sure that the client feels safe in school…so does that mean you have a buddy system when you use the bathroom or during passing time?...working with the school around that kind of stuff. At home, does the child feel safe at home, what can the parents do to combat what the reality is outside sometimes?

The other manager added,

I try to help empower the client and the families. We say, "Okay these things happened and what's the next step; what do you need to do to feel safe? What are some things you need?" and kind of helping to empower the families in that way…and validate their experience.

On the contrary, clinicians from focus group B and C felt less confident in the direction of how to navigate their role in supporting youth with issues regarding community violence. A clinician from focus group B seemed to capture the feeling in just one word: "helpless." She said,

There's some level of helplessness too… what can I *really* do? I can be there for the client but how do I increase their safety if they're dealing with things like "I can't move

out of this place" or, I don't know…it's just hard. I know how I can be there, but I don't know how I can help make a bigger change.

Following this comment, another clinician from focus group B added,

Sometimes it feels like a Band-Aid. It's like, they're going back, I gave them so much support, so much empathy, so much validation, trauma work but they're going back – most of the time to the same environment and what do you do?

Another clinician conveyed the same feeling of helplessness by adding,

How much can you say if it's something reoccurring and you keep giving the same advice or the same kind of intervention? Then after a while, I know for me, I wouldn't want to hear that anymore because it's not helping me. So what am I going to do now? Like, the situation isn't changing so sometimes it's hard to know…am I being effective if I just keep giving the same thing?

A clinician from focus group C shared the same sentiments, stating,

We're putting them right back into the environment that they're in, so it's like kind of that double-edged sword. It's like, we're doing work, but it's not getting implemented because you're going straight back into the environment and we can't change other people's behaviors so it's like you have to be self-aware of those things.

Similarly, another clinician commented,

I think I view my role as being supportive and assisting in any way therapeutically that I can if this is something that's heavily impacting them. But, I can't do anything to prevent their experiences – we can't do that for anybody. So, just kind of being there and seeing what do they hope for the future, and thinking, what do they need to process what they have already experienced. I think that's the most at this point that I feel that I can do.

Clinicians' helplessness about how to navigate these systemic issues as a micro level clinician appears not only to come from feeling unimaginably overwhelmed by the entirety of this epidemic of community violence, but also feeing uncertain about the agency's position in terms of how to address said issues. For example, one clinician stated,

> I'd say [addressing community violence is] part of the [agency's] mission statement. The action of it I'm less clear on. I think there are good intentions; it's, like, how to put them into action is where I'm not really clear on what we do to address community violence, other than like when we ask questions in our screening evaluation.

Another clinician added,

> …and provide therapeutic support. So, helping clients process any trauma related to community violence but then what really more are we doing? Yeah, we work with a lot of children and teenagers that have anger and have tendencies to be violent, so that's one way of intervening, but I think in a bigger picture, I'm not sure.

How the Agency can Provide Clinicians Support

Clinicians believe that the agency, as a whole, recognizes that community violence is a prevalent issue. They see combating this issue as a part of the agency's mission statement and it factors into the "day-to-day operations" that include the work clinicians are responsible for practicing. The agency consistently keeps its employees informed of significant issues as they happen. Clinicians from both focus groups talked about the fact that "emails are being sent out to update us about shootings." In regards to said emails, some clinicians wish for more than what has been said in the emails, such as suggestions from the agency with concrete tools with which clinicians can implement. For example, one clinician said,

I feel like it was a lot of general information [in the email] and encouragement to have the conversation [with clients] but not very much in terms of concrete tools about how do you have those conversations. It's sort of assumed that it's just like really easy to pick up and start talking about it but, as a result we don't we don't end up talking about it all that much.

A clinician who agreed with this statement, responded, "I think we need more training and ways to discuss it and bring it up…I don't think we're trained well enough or competently enough to really kind of tackle that unless it's in a specific evidence based model." Another clinician who shared these same ideas elaborated on this concept. She expressed wanting more of a response from upper management, but admitted that the practical application of providing more is both tricky and confusing.

I want it to be addressed more. I want people to acknowledge that there are people every day who are going into these communities putting themselves at risk. There are incidents happening right around us and sometimes even our building being impacted by bullet holes. It gets noticed but maybe not talked about. I think it's this delicate topic where maybe because we don't know what to do or how to fix it it's hard to bring it up…and I don't know that I have any good suggestions…I think agency wide, I feel like it's kind of a topic that people – they want to go there, but then they worry about going there. Like, are we going to incite fear and panic in our employees…especially those who have to go in home and are in these communities every day?

Professional Education Received in Preparation of Treating Community Violence

The majority of participants in this study received their Master's degree in Social Work, while the rest received their degree in either Art Therapy or Marriage and Family Therapy, but

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nonetheless, I assumed that their professional education had prepared them to address and/or treat the problem of community violence. After surveying participants, I found that most all participants had learned about this topic in graduate school but to varying degrees. For example, one clinician said,

> It was discussed in kind of like an open forum but nothing was, like, implemented as in "this is a tool" of how to do it. It was more, like, be aware that this is going on and use a trauma lens. It was more trauma-focused than how do we deal with it on a big scale.

Many other clinicians agreed, adding, "I feel like it was addressed in terms of looking at contextual considerations;" and, "I know that it was something that was brought up in my MSW program but I don't think it was something that we went into a lot of depth about – about how to treat and about how to work with."

However, it seems as though clinicians and managers have been able to build on what they had already learned in their graduate education while working at Agency X. One participant stated, "What I've learned about it has more so been on the job training;" while another said, "I don't really recall getting much time in school on this particular topic, but in my year that I've been here, I've practiced really looking at every client with a trauma lens."

Summary

The findings presented in this chapter are comprised from three different focus groups at Agency X, Hartford: two focus groups involving only clinicians and one focus group involving only managers. Findings reveal clinicians' were able to articulate their opinions about and discuss clinical skills they use to address the issue of community violence in Hartford, and they provided their reasoning for continuing work in the field. While the purpose of this study was to examine what clinicians and managers at the Enhanced Care Clinic are doing to integrate an

effective collaboration between micro and mezzo/macro level interventions in addressing youth

exposure to community violence, in some ways, clinicians respectfully questioned this same

enquiry. Clinicians muddled through their feelings of helplessness and other complexities related

to this widespread issue, raising more questions of how to create effective change for youth and

their communities. The following chapter will critically examine the findings as well as compare

and contrast the findings to the relevant literature published on this topic.

CHAPTER V

Discussion

The objective of this study was to examine what clinicians and managers at the Enhanced Care Clinic are doing to integrate an effective collaboration between micro and mezzo/macro level interventions in order to help youth clients residing in Hartford who are witness to and/or involved in community violence build competent communities. This focus group study explored clinicians' and managers' perspectives of community violence in Hartford through a variety of questions. The results confirm that community violence is a widespread issue for Hartford youth. Clinicians' and managers' perspectives of this issue influence their ideas about Hartford's youth, and thus affect the clinical interventions they use (or don't use) during sessions with clients. Findings also conclude that clinicians and managers assume variant advocacy and counseling positions in supporting youth from their position within the clinic.

In the sections to follow, I will discuss clinicians' and managers' answers to the focus group questions and how their answers compare and contrast to one another, and to the previous literature review. Implications for social work practice: how clinicians and manages at the Enhanced Care Clinic can enhance their practice with youth exposed to community violence will be addressed. And lastly, recommendations for future research related to this topic will be noted.

A Comparison of Participants' Answers to the Literature

As previously written in the Findings Chapter, all fifteen participants agreed that clients at the Enhanced Care Clinic have been traumatized by community violence. They all considered

community violence to be a prevalent, ongoing issue and likened its effects as a "web" that reaches all members of the community in some capacity. These answers are reflective of the reality that inner-city neighborhoods are characterized by high levels of community violence.

Clinicians and managers agreed that initiation of conversation about clients' victimization and possible traumatization of community violence starts in the assessment phase; particularly as a part of a standardized trauma screen. Assessing a youth's community violence exposure is often a standardized part of treatment, especially when working in neighborhoods populated with violence. Information and details are then usually incorporated in the psychosocial profile of a client. But as the clinic's assessment framework stands, there are only a few questions that ask about a youth's exposure to community violence. Furthermore, these questions are framed through a "trauma lens." Though community violence can precipitate a form of trauma, using just a trauma lens negates clinicians and managers assessing this issue from a systemic lens.

Neil B. Guterman and Mark Cameron (1997) of Columbia University School of Social Work developed a specific assessment framework for young people exposed to community violence after finding that little attention to the systemic perspective regarding this issue are present in the field of social work literature. Their framework delineates four domains: identification, sequelae assessment, lethality assessment, and ecological assessment (ISLE). ISLE can be used by social workers "to map the role of exposure to community violence in a young clients' life…to examine ecologically based risk and protective factors and intervention options" (p.500). In other words, this model is designed to incorporate aspects of micro and mezzo/macro level systems into the assessment and treatment of youth exposure to community violence. Guterman and Cameron concluded that "attention is necessary not only to assessing the young victims of violence, but also to addressing [broader] institutional and interpersonal

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influences that allow such behaviors to persist" (p.502). This assessment framework may be a helpful tool for clinicians and managers at the Enhanced Care Clinic to address the "multilevel challenges for young people and their families at risk of exposure to community violence" (Guterman & Cameron, 1997, p.502).

Participants have, however, considered some of the broader institutional and interpersonal influences which contribute to the source of community violence. Their answers were categorized into sub-themes which were: intergenerational violence; mixed messages about violence from caregivers; peer pressure from social groups; youth upholding their social reputation; gang-related activity; low economic status; lack of opportunities/resources; drug use and involvement; and institutional oppression. Their answers are consistent with that the literature included as sources of community violence, and matched what other empirical research has found to be contributing factors as well. These factors include

> the absence of adult supervision and monitoring, a dearth of safe places to gather, the
> absence of constructive activities during idle periods, increased exposure to law
> enforcement and prison settings, and diminished opportunities for interaction between
> disadvantages youth and middle or upper-class professionals who can provide role
> models and institutional resources (the National Research Council Staff, 1996, p.14).

Participants added the *normalization of violence* as a contributing factor to a source of community violence, which is also consistent with literature in the field of orthopsychiatry and social work. Participants believed that because youth have been exposed to violence at a young age, either in their home or community, this has led them to accept and perpetuate violence. As discussed in the literature review, research by the Word Health Organization indicated that the

social norm a community creates around the notion of community violence either encourages or discourages the use of violence.

Furthermore, support from other literature sources suggests that "children and adolescents living in high-crime urban areas become psychologically desensitized from repeated exposures to violence, which spares them from immediate emotional distress (psychological numbing) but increases their propensity to violence" (Ng-Mak, Salzinger, Fledman, & Stueve, 2002, p.93). Guterman and Cameron (as cited in Ng-Mak et al., 2002) argued that "inner-city violence has been portrayed as a way of life (p.93);" and Hinton-Nelson, Roberts, & Snyder, 1996 (as cited in Ng-Mak et al., 2002) has stated it is "an overall norm" (p.93). Based on these theories, Ng-Mak et al. (2002) hypothesized that "pathologic adaptation to community violence (i.e., exposure to violence results in a desensitization to it, which then blunts the affective effects of violence while magnifying the behavioral effects) arises from normalizing *cognition* about violence" (p.95). To my knowledge, no research on this theory has been tested yet. But it is important to consider because there are so many models and programs in response to community violence that focus on youth's cognitions about violence (e.g. conflict resolution strategies) as the cause for perpetuation of violence.

Additionally, challenging the role of policies and other institutional forms of power which enforce the "normalization of violence" should be challenged. Otherwise, it discounts the racist and oppressive systemic policies/constructs imposed by people in power on communities of color, and especially that community's vulnerable youth, who are trapped in the violence of that Hartford neighborhood. One clinician participant did speak of the historical housing inequalities that communities of color – specifically Black and Hispanic – have been subjected to and still face today. Overall, it is clear that clinicians and managers at Agency X are aware of the

injustices their clients face, and are thinking of these while developing an understanding of their client in relation to their symptoms; but also in the ways they provide treatment for youth. However, encouraging and empowering youth to consider these their own social identities and how this fits within dominant culture standards while challenge their own cognitions about using violence as a "normal response" could be a pivotal factor when applying clinical interventions to youth exposure and victimization of community violence.

Overall, there was a general consensus that clinicians and managers believe the agency recognizes community violence as a prevalent issue for youth clients, and confirmed the agency's aspirations to respond thoughtfully and sincerely about these matters. Participants reported several occasions where administrative staff has emailed clinicians and managers notifying them of violent incidents which happened in the community. They also spoke of luncheons and support groups following an incident of community violence where clinicians and managers were able to process these events and discuss further ways to help youth traumatized by these incidents. Managers confirmed that it is part of the agency's agenda to continue to respond to employees' and community members' concerns in the aftermath of an incident involving community violence. However, at this point, managers believe that it is not part of the agency's mission to initiate *prevention* work around community violence. Clinicians confirmed that addressing community violence in Hartford is a part of the agency's mission statement as well, and said that addressing violence factors into the "day-to-day operations" at the clinic, which includes clinicians talking about community violence with clients.

Within their respective roles, it appears that managers and clinicians assume variant positions about their involvement in advocacy work and how they view their role within the agency in combating community violence. Managers appeared to have a clear understanding and

trajectory about how they advocate for youth. They help to respond to clients, families, and community members in times of crisis, and have been partnering with other agencies (i.e. schools, recreation centers in the community) to strengthen their commitment to the agency's mission statement. They are the first point-of-contact to help organize outreach work in supporting clients and families in the aftermath of an incident involving community violence.

On a micro level, managers act as liaison between the clinic and community members. When working with youth, managers often use safety planning as an important way to intervene. Managers also mentioned empowering youth and families as a way to validate their experiences. When managers discussed ways in which they "empower" youth and families, they did not discuss in detail *how* they empower youth. Implementation of La Roche and John Tawa's (2001) empowerment model could be effective with Hartford's youth population. However I believe having professionals who understand institutional racism and who can work with youth to process their lived experiences are essential to this application. Also, clinicians and managers must work with clients to help them question the stereotypes and "normalization of violence" as they have been imposed on them through generational oppression while living in a racist nation. These "dynamics can directly affect adolescents' views of their own identity and the opportunities available to them, leading to growing isolation" (National Research Council Staff, 1996, p.14) from any positive social influences designed to create a network of support if discussion and understanding about the intersection of racism, identity formation, and violence does not occur.

Some clinicians, on the other hand, did not appear confident in their understanding of how they advocate for youth. Clinicians understand that advocating for youth victims of violence is a part of the mission statement, but reported feeling less clear in their understanding about how

community violence is being addressed by the agency and what role they play in this. One clinician in particular stated that she finds the luncheons and support groups to be helpful for her own understanding of what happened; however feels that there are no "concrete tools" on how to advocate for clients. With this, she reported, came a feeling of helplessness – which was an underlying theme throughout both focus groups. Clinicians appeared overwhelmed by the complexities of community violence and reported feeling like there is not much they can do other than process community violence issues with clients as they present during sessions through a specific trauma treatment model or simply by providing therapeutic support. I could not find any relevant research on clinician's feelings of helplessness in relation to treating youth exposed to community violence. Perhaps this may be a recommendation for future research in learning how clinicians may work with similar populations.

As stated in the literature review, the most effective strategy that youth and community leaders may implement to help youth overcome risk factors associated with community violence is creating a strong support system of adults/mentors and family members as well as positive resources within the neighborhood (e.g. recreation centers) to provide guidance and foster a sense of safety and security for youth. "The strength and quality of social networks in economically disadvantaged neighborhoods may affect the types of adult interactions that youth experience, which can influence their choice of role models and life course options" (National Research Council Staff, 1996, p.11)

But as clinicians pointed out, this can be difficult for a few of reasons: (a the youth's social group is highly influential in upholding a "tough" reputation, (b the youth's family members may encourage the use of violence, and/or (c the children of Hartford are often left with a paucity of positive adult role models of the same race and ethnicity in their community to

encourage and lead them to make constructive life choices. Demographically, the majority of participants of this study are white females; and though this is not representative sample of the demographics of employees working at the clinic, it nonetheless highlights an obvious reality that most of the youth who receive services at the clinic have at least one professional role model in their life whose life experience differs from their own because of the professional's race, ethnicity and/or social class.

Having positive adult support is a protective factor necessary for helping youth victims to cope with the emotional impact of community violence. It is also necessary for creating community change, but

movement of many middle and upper-class individuals out of poor communities, along with the loss of many minority males because of early death or incarceration, has diminished the network of human resources within the community and reduced the opportunity for youth to interact with adults who can offer advice, support, perspective, and experience in negotiating school-to-work transitions, the initiation of sexual relations and other key challenges during adolescence (National Research Council Staff, 1996, p.13)

Without the presence of non-white adult leaders in neighborhoods like Hartford, role models who can share similar life experiences with youth and provide encouragement and empowering advice to their younger generation, it is perhaps more challenging to provide cohesive community support.

According to the National Research Council Staff of Youth Development and Neighborhood Influences (1996), "prevailing views of adolescent development and conceptual framework derived from white, middle-class adolescent populations may not reflect the

experiences or unique challenges that confront youth who are influenced by other cultural traditions or by disadvantaged conditions;" (p.11) and therefore, some clinicians' approach to alter youths' ideas that they must live up to a reputation of "being tough" could potentially lead to an impasse in treatment.

Furthermore, "traditional theories of normative development do not necessarily provide appropriate conceptual frameworks for studying the lives of inner-city teens" (National Research Council Staff, 1996, p.11). Burton et al. (as cited in National Research Council Staff on Youth Development and Neighborhood, 1996)

> concluded that the developmental paths of those who grew up in poor, high-risk neighborhoods are based on ideologies, role expectations, behavioral practices, and rites of passage that provide a social context that differs from that commonly reported in studies of white suburban middle-class teens (p.11).

Since white supremacy bias can exist even within the literature from which clinicians and managers are learning, it is probable that a continuation of this bias might be repeated in clinical practice, thus creating a therapeutic fallacy in the clinician's understanding of and providing treatment for youth exposure to community violence.

Thus participants were asked to share if they received any preparation to assess or treat the problem of community violence in their professional education. Participants reported they felt as though their graduate education did not prepare them to treat the problem of community violence. Some clinicians reported they have learned how to treat youth exposure or traumatization of community violence through on the job training. Still, clinicians feel "helpless" in supporting youth with these issues. A few clinicians suggested the agency provide more

training with information on how clinicians can respond and provide clinical interventions to support Hartford's youth.

Implications for Social Work Practice: How Social Workers can enhance their Practice with youth Exposed to Community Violence

Social participation in the client's community is an essential part of clinical practice when working in a community-based agency. Assessing a client's social environment and the systems involved in a client's life is a foundational practice to providing holistic treatment. Extending beyond this, understanding the culture of an environment is the catalyst for creating change. Hardcastle (2004) wrote

> without community knowledge and skill, the social worker is limited in the capacity to understand and assist clients in shaping and managing the major forces that affect their lives and the capacity to help clients empower themselves to develop and manage personal and social resources (p.6).

The findings of this study suggest that clinicians at the agency are incorporating micro and mezzo/macro level interventions in their practice to help Hartford youth build competent communities. The literature in this study has suggested ways in which participants can enhance their practice as related to this topic area. For example, adapting Guterman and Cameron's (1997) assessment framework may be a prerequisite to implanting techniques from La Roche and Tawa's (2011) empowerment model to help youth understand the contextual embeddedness of their symptoms. With these tools, clinicians and managers might explore how youth can gain social capital within their neighborhoods to help intervene with community violence. Ohmer, Warner, and Beck (2010) sought to examine the development of social capital and informal social control in low income neighborhoods with high violence rates. In their study, community-

based social workers were provided with the skills to help clients safely and effectively gain informal social control. Most notably, this study mirrors La Roche and Tawa's model in that the clinicians, or trainers of Ohmer, Warner, and Beck's study used "story telling" as a model to help youth

> understand the relevance of norms…[process] what they believed the norms were within their neighborhood …which allowed youth to being to understand neighborhood norms as others saw them, and began a process in which non-normative behavior was defined through communication and interaction among group members (informal social control) (p.169)

Results of this study demonstrated that participants who were involved in the training on how to build informal social control were more likely to use direct, non-violent interventions when intervening in neighborhood problems involving violence. In sum, clinicians and managers may consider incorporating some of the literature in this study to enhance their practice with youth victims of community violence.

Study Limitations and Recommendations for Future Research

Results of this study indicate the importance of qualitative research to learn how clinicians and managers at the Enhanced Care Clinic assess and treat youth exposure to community violence. Findings illustrate specific strategies and information that clinicians and managers may consider to enhance their clinical practice with Hartford youth. In retrospect, having more managers be included in focus group discussion would have allowed for a better representation of managers' perspectives and opinions about this issue. Additional research examining if there is a relationship between clinicians/managers who work at the clinic *and* live in the community possibly have enriched these data, given that previous research has shown that

support from professional role models from the community can help youth adopt prosocial behaviors. Expanding on this, another recommendation for how this research may be enhanced would be to examine whether or not there is a relationship between the amount of time a clinician/manager has worked at this agency in Hartford and how well prepared they feel to asses and treat youth exposure to community violence. Nonetheless, this study provides important data and supportive evidence that clinicians and managers may use to further explore the issue of community violence in Hartford, and how best to make interventions.

Social work is a practice that often tackles three categorical systems simultaneously: micro, mezzo, and macro level practice. Yet at the same time these systems are inseparable in many ways. As a whole, they often work together (or against each other) as they continuously influence clients' lives, while influencing each other. It is therefore tremendously important for social workers and other mental health professionals who practice individual therapy with clients and families to not only understand these distinctive levels of social work, but to actively be aware of and, perhaps, be involved in each of these systems. Mental health professionals who work in community-based agencies are members of that community too; and as members of the community, professionals must come together and help confront challenges the community faces. With Hartford's community violence rates at an all-time high, clinicians and managers do and must continue to explore with youth and families the multiple conceptualizations of the various systems influencing their lives. In turn, this will help youth and families to be self-aware of their own morals and values, and feel competent in developing the skills to address community violence.

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Hello!

My name is Alicia Mamula. I am an intern here and a 2nd year graduate student at Smith College School for Social Work and <u>I NEED YOUR HELP!</u>

I am conducting a study to examine what interventions and/or skills clinicians and managers at the agency are using to address the issue of youth exposure to community violence during session, and within the agency at large.

There will be two focus groups. Please choose ONE to attend:
Wednesday, March 16, 2016 @ 12:00pm in room 127/128
Tuesday, March 15, 2016 @ 11:45am in the conference room

To participate you just need to meet these criteria:

1) You work at agency full time (forty hours a week) or part time (less than forty hours a week)

2) You have a Master's Degree (in Social Work, Art Therapy, Marriage and Family therapy, Counseling, Psychology, or PHD in Psychology).

Focus group sessions will be about 45 minutes long (depending on length of discussion). We will schedule the groups for lunchtime and have pizza as compensation for your time and participation in this study.

If you are interested in participating, please contact me via email at xxx@xxxx.xxx

All materials and data collected will be kept strictly confidential and information will be shared in aggregate form and/or by individual examples but not in a way that the individual participants will be identified. For example, direct quotes from clinicians/counselors/managers may be included in the final paper but that person's name and other personal information will be kept confidential. I will use this study to complete my Master's thesis, and use the results in a presentation.
This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects

Review Committee (HSRC)

SMITH COLLEGE

2015-2016
Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA

………………………………………………………………………….

Title of Study: A Clinical Response to a Community Issue: Exploring Hartford's Youth

Exposure to Community Violence in a Community-based Agency

Investigator(s): Alicia Mamula, MSW Intern

………………………………………………………………………….

Introduction
- You are being asked to be in a research study to share your clinical thoughts and skills with other Agency X clinicians about the issue of Hartford's community violence, and ways that you have addressed this issue with clients during session and within the agency at large.
- You were selected as a possible participant because you are a full or part-time clinician at Agency X, and have a master's degree in in social work, counseling, art therapy, psychology, marriage and family therapy or PhD in psychology.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
- The purpose of the study is to examine what clinicians and managers at Agency X are doing to integrate an effective collaboration between micro, mezzo and macro level interventions to help Hartford youth client's *competent communities* – a community that has the ability to respond to the wide range of member needs and solve its problems and challenges of daily living.
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures
- If you agree to be in this study, you will be asked to do the following things: You must sign this consent form prior to the beginning of the focus group and return it to the researcher. You may attend one focus group at either Agency X locations. It is required that you complete a demographics questionnaire at the beginning of the focus group. During the focus group, you will be asked a number of questions related to the prevalence and frequency at which the topic of community violence is discussed during session with clients and within your role as a clinician at the agency. Focus groups will take place at work during the day (i.e. lunch hour or a separately assigned meeting time) for approximately 45-60 minutes

(depending on the quality and length of discussion).

Risks/Discomforts of Being in this Study
- There are no reasonable foreseeable (or expected) risks. However, should you feel any anxiety or distress while participating in this focus group you can chose to opt out of participation in the focus group at any time.

Benefits of Being in the Study
- The benefits of participation include the enrichment of each clinician's professional practice as an employee with Agency X. Focus groups allow for a natural flow of conversation between participants about one another's perceptions, ideas, and attitudes regarding a specific topic. All participants would hear from one another about ways they can become more aware of their own clients' experience with community violence and thus implement effective clinical skills to address the issue of community violence within their individual practice and the agency at large. Clinician's will have the opportunity to inform colleagues of intervention methods they themselves may have developed to address this issue.
- The benefits to social work/society are: Data may help social workers in community-based agencies better assess and reevaluate the needs and resources of youth and families in urban communities.

Confidentiality
- Your participation will be kept confidential. Information obtained from you in the study will be revealed in aggregate form and/or by individual examples, but not in a way that you or other participants will be identified. For example, direct quotes will be included in the final paper but that person's name and other personal information will be kept confidential. However, since data will be collected in focus group format, all participants will know who else has participated and what information they provided. I will ask that participants keep this knowledge confidential, but will not be able to prevent participants from revealing information outside of the groups.
- Even though responses will be disguised, participants will be drawn from a relatively small pool, so it may be impossible to disguise responses sufficiently to prevent a non-participating agency employee be able to guess participants' identities should they read the final report, but I will do my best to disguise information in my final report.
- It is also important to note that agency staff may be involved in recruitment and/or participation process. If, for example, staff is assigned to work with me, it may be likely they will know participants' identities, or see data once it is collected. If any agency staff (other than participants) is involved in the research of this study, I will ask that all knowledge of participants involvement in the study be kept confidential, but will not be able to prevent agency staff from revealing information outside of involvement in the study.
- In addition, the records of this study will be kept strictly confidential. Participants will be video recorded on my personal tablet device for the entire length of the focus group. Video recordings will be stored on the tablet and my personal laptop (for back-up purposes) and those files will be password-protected. Transcriptions will also be stored on my personal laptop and will be password protected, and signed consent forms will be stored separately in a secure locked cabinet.
- All research materials including recordings, transcriptions, analyses and consent/assent

documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift
- Each participant will receive pizza for lunch for their participation. This compensates for your time and participation in the study. Pizza will be provided at the end of the focus group after data have been collected. If a member chooses to end participation before data collection is complete, they will still be able to participate in the lunch if they choose.
- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw
- The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely. If you choose to withdraw during the focus group, any conversation material or information you've provided will be a part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns
- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent
- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

………………………………………………………………………………..

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

………………………………………………………………………………..

[if using audio or video recording, use next section for signatures:]

1. I agree to be [audio or video] **taped for this interview:**

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher: _____ Dater: _____

APPENDIX C

The following 6 questions will be asked during focus group sessions. Sub-questions will be used as prompting questions to help focus the discussion and elicit more detail.

1) Do you get a sense that clients at the agency have been traumatized by community violence?
   a) How big of a problem is it – do just a few clients present with this problem, or is it widespread?
   b) If it is a problem, how do you initiate conversation with a client about their victimization and possible traumatization of community violence?

2) How do you understand the source of community violence in Hartford?

3) How do you think the agency thinks about community violence?
   a) Do you think it is part of the "culture" or mission of the agency to address this issue? How so?

4) How do you advocate for youth victims of community violence?

5) What do you see as your role within the agency in combating community violence?

7) Have you received any preparation to assess or treat the problem of community violence in your professional education?

Title of Study: A Clinical Response to a Community Issue: Exploring Hartford's Youth Exposure to Community Violence in a Community-based Agency

Demographics Questionnaire

1. Name: _____

2. Gender: _____

3. Ethnicity: _____

4. Years of clinical experience: _____

5. Years employed at the agency: _____

6. Academic discipline: _____

7. Have you received any preparation to assess or treat the problem of community

violence in your professional education?

Yes   No   Somewhat

☐   ☐   ☐

APPENDIX E

From: Mannula, Alicia
Sent: Wednesday, January 13, 2016 12:46 PM
To: Sanghavi, Total
Cc: Corto-Mergins, Catherine
Subject: FW: Community Violence Project

Good morning Total,

A few months ago I emailed Catherine Corto-Mergins about conducting a research study here atmPHU The research study will be used for my thesis, as I am currently a second year graduate student at Smith College and an intern

I have reviewed my project with my supervisor, Beth Meekins, and Mandy Hemmelgafn, who have both approved the study to be submitted to the IRB for final approval. Attached is the completed IRB short form and the necessary appendices. The deadiine for approval according to Smith College is January 22nd, which is next Friday.

I look forward to hearing from you soon.

     Thank you, Alicia Mamula

From: Corto-Mergins, Catherine **Sent:**
Wednesday, January 13, 2016 1:55 PM
To: Mamula, Alicia; Sanghavi, Toral
Subject: RE: Community Violence
Project

Hi Alicia, Thank you for your submission of this, i was wondering what happened, as 1 know we spoke quite awhile back about this. I will be happy to submit this to our IRB, however, it will not be approved by your deadline of next Friday. Usually the approval process takes 2-4 weeks, if not longer. I can send it out to the committee, but we will need more time. Let me know if that will be a factor for you going forward. Thanks. C

Catherine Corto-Mergins, LCSW ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮
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FW: IRB feedback for your proposed study
2 messages

Mamula, Alicia <amamula|flHHiBHIil   '^■'1, Feb 12, 2016
at 2:14 PM
To: "amamuia@smith.edu" <amamu!a@smith.edu>

From: Corto-Mergins, Catherine
Sentr'Friday, February 12, 2016
10:01 AM **To:** Mamula, Alicia
Subject: IRB feedback for your proposed study

Hi Alicia, 1 am attaching a document with feedback from the IRB members. At this point, there
is not enough information for us to make an accurate evaluation of your proposed project;
Please review the comments and if you want to resubmit for the committee to evaluate, please
provide information for the areas indicated. Let me know if you have any questions. Thank you.
Catherine

Catherine Corto-Mergins, LCSW

Hi Catherine,

Thank you again for all of your comments and suggestions, and for really helping me usher this study along. I have thought a lot about adding a third focus group to the study and I've come to the decision that because this this a finite study which focuses on clinicians who are working directly with clients and the interventions they are using, I will forgo the decision to include a focus group with the operations team.

To clarify from our discussion yesterday, do I still have your approval to move forward with this study?

Thank you,

Alicia Mamula

FW: thesis related
3 messages

Mamuia, Alicia <amamulc _____
To: "amamula@smith.edu" <amamula@smith.edu>

From; Corto-Mergins, Catherine **Sent:** Wednesday, February 24, 2016 10:07 AM **To:** Mamuia, Alicia
Subject: RE: thesis related

Alicia, That is fine. Good luck with your work. C

Catherine Corto-Mergins, LCSW | ▬▬▬▬▬▬▬▬▬▬▬▬
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