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RESILIENCE IN ADVERSE CONTEXTS: YOUTH AND CLINICIAN PERSPECTIVES ON NAVIGATING COMMUNITY VIOLENCE IN CHICAGO

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ABSTRACT

This dissertation explores the landscape of youth navigating community violence in Chicago, drawing from the perspectives of both youth and trauma clinicians. Through semi-structured interviews and a youth focus group, participants discuss their experiences with community violence by exploring coping mechanisms, survival techniques, and adapted behaviors.

This dissertation challenges conventional notions of resilience, revealing how survival becomes synonymous with resilience in environments with ongoing trauma and structural adversity. Through a nuanced exploration, it uncovers the adaptive nature of behaviors traditionally classified as maladaptive, contextualizing them within the harsh realities of community violence. Moreover, it emphasizes the critical role of accessing basic needs in trauma recovery while also advocating for a deeper understanding of community violence as a structural issue perpetuated by systemic inequalities.

Surviving in such environments demands a diverse toolkit of survival techniques, and youth participants openly explore the range of strategies they employ to mitigate the impact of violence on their lives. From avoidance practices to creative outlets, each narrative offers a glimpse into the survival, resilience, and adaptability inherent in youth exposed to community violence.

Furthermore, participants leverage their firsthand experiences to provide invaluable recommendations for improving clinical training and trauma treatment. Drawing from their encounters with violence and its aftermath, they offer insights into the nuanced needs of youth exposed to ongoing trauma. These recommendations serve as a roadmap for healthcare professionals seeking to enhance their understanding and responsiveness to the complex

relationship between trauma and community violence. By amplifying the voices of those directly impacted, these suggestions pave the way for more contextually and culturally competent approaches to trauma training and treatment.

Ultimately, this dissertation calls for a paradigm shift from merely surviving to fostering environments where youth can truly thrive. It challenges existing systems and calls for a concerted effort to address structural violence. This research also advocates for immediate action in providing essential needs and psychological support within the same space, paving the way for a more compassionate and equitable approach to trauma treatment and community well-being.

INTRODUCTION

This dissertation is an extension of a previous project that explored the grief and mourning experiences of young Black women who lost a Black male loved one to homicide. This phenomenological analysis illustrated how young Black women navigated grief, trauma, and cumulative loss without formal support in the context of community violence exposure. The findings of that research demonstrated that while these women experienced insurmountable traumatic losses that significantly affected their psychological development, they still reported how they had to maintain their jobs, stay in school, and raise their children.

Because of their ability to cope and function with this level of violence and loss without access to formal support and still be able to care for themselves and their children, these young women were often described by the public as resilient. While these women were labeled resilient, many of them would say they were surviving and doing what they had to do. The classification of these behaviors as resilience prompted the current study's exploration into resilience, recovery, and coping in the context of community violence exposure. This study observes how Black youth affected by community violence align with or defy the traditional framework of resilience.

Resilience is an evolving construct and framework that explains the process of how humans adapt to adversity (Schetter & Dolbier, 2011). It began when researchers struggled to understand how people overcame adversity and hardship. Two people with similar backgrounds and equal resources can experience the same trauma but have distinct outcomes. The phenomenon of resilience developed when studies showed that individuals can have a relatively good outcome despite exposure to risk or adversity (Rutter, 2007).

Resilience is crucial to studying community violence. It provides a lens to understand how individuals and communities navigate and cope with the challenges posed by violence. Furthermore, resilience serves as a protective buffer against the adverse health and social implications associated with community violence exposure (Woods-Jaeger et al., 2020; Copeland-Linder et al., 2010). Due to the unique context of community violence, research suggests that this demonstration of resilience may be equally unique and potentially different from many traditional understandings (Woods-Jaeger et al., 2020).

One of the most commonly used explanations of resilience comes from the American Psychological Association, which defines resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress—such as family and relationship problems, serious health problems, or workplace and financial stressors" (2012). The existing research on resilience is complex, and there is no uniformly accepted definition (Scudder, 2008). While there is no uniform definition, resilience is widely understood as a construct that incorporates the bidirectional interaction between people and their environments while also including additional contextual factors such as family and community (American Psychological Association [APA], 2008).

From advancements in resilience research, scholars realize that isolated events of adversity and trauma are different from ongoing and chronic exposure to trauma. Additionally, coping and resilience manifest differently when people do not have the same access to support and protective factors. (Woods-Jaeger et al., 2020). For groups experiencing elevated levels of adversity but having less access to support, their protective factors and coping mechanisms will challenge the traditional understanding of resilience (Steinhardt, 2008). For instance, research has shown that youth exposed to community violence employ coping mechanisms traditionally

seen as maladaptive but adaptive in those contexts (Gaylord-Harden et al., 2017; Woods-Jaeger et al., 2020). The tools employed and acts of resilience demonstrated within exposure to ongoing trauma will vary greatly from lower levels of stressors or adversity. This finding demonstrates that resilience is contextual and drastically changes by circumstance.

While resilience is extensively studied throughout various disciplines, there are still significant gaps in understanding how resilience and the process of recovery are exhibited within ongoing exposure to trauma, such as community violence exposure. Because of this, researchers struggle to classify how acts of adapting and surviving fit into the traditional mold of resilience (Woods-Jaeger et al., 2020; Yule et al., 2019).

This project explores how youth living in communities with elevated rates of violence adapt, as well as how they challenge and defy the traditional framework of resilience by exploring their protective factors, trauma responses, coping mechanisms, and survival techniques. I intend to explore the concept of resilience to understand how it shifts based on circumstances and context, with a particular focus on trauma stemming from community violence through the following questions:

1) What does resilience look like in the face of exposure to community violence?
2) What are the differences between survival, resilience, and adaptation?
3) What does it mean to "adapt well" to community violence or continuous traumatic stress?
4) How does youth exposed to community violence demonstrate duality in maladaptive and adaptive coping mechanisms?

Literature

The history of resilience spans multiple disciplines and evolves our understanding of human adaptation to challenges (Southwick, 2014). The development of the concept of resilience began by exploring how people respond to and overcome adversity. One approach to exploring resilience was through a biological perspective, which viewed resilience as an innate trait. Discoveries in neurobiological evidence have shown differences in brain structure, neural characteristics, and pathways that make some people susceptible to poor psychological outcomes after exposure to extreme risk (Cross, 2017). The biological understanding of resilience is often viewed as binary, meaning some people are born with genes that help them have stronger biological responses to stress and make them less susceptible to developing maladaptive coping mechanisms (Liu et al., 2018). While research supports the biological data and traits related to resiliency, resilience is not a personality or observed trait (Rutter, 2007). A person can have innate traits and behaviors associated with resilience, but resiliency must be operationalized with adversity (Oshio et al., 2018; Graber et al., 2015).

Furthermore, Bonanno (2021) acknowledges that while we can create links between traits such as emotional expression and optimism to resiliency, there is a paradox. The resilience paradox is that even with the knowledge of these correlations, we are still unable to accurately determine who will be resilient and who will not be (Bonanno, 2021). Resilience is an ex post facto, meaning the outcome of resilience is studied after the presence of adversity (Mancini & Bonanno, 2009). Adversity and stressors are necessary to form resilience (Woods-Giscombe et al., 2023). Additional research suggests that resilience is not a set of personality traits but the constellation of stressors and resources (Springfield et al., 2022).

Early research on resilience focused on the association between children's exposure to adversity and positive outcomes. In the early 1900s, researchers wondered how children managed to deal with challenging circumstances such as extreme economic disadvantages, such as the Great Depression or natural disasters. In the 1950s, Werner and Smith conducted a longitudinal study on how children were impacted by impoverished conditions. From the results, many of the children had poor health and developmental outcomes, but about one-third of the participants had strikingly more positive outcomes (Werner, 1986). Before this research, children exposed to adversity yet exhibited positive outcomes were seen as extraordinary and focused on internal characteristics that made children resilient (Graber et al., 2015; Masten, 2001). During this period, researchers found that children's resilience was not extraordinary but a part of essential human adaptation (Masten, 2001). The findings from Werner's study shifted the focus to exploring what protective factors children possess or have access to that may mitigate the impact of risk (Luthar, 2000; Graber et al.,2015). More contemporary psychologists and researchers then began to examine multiple factors that contribute to resilience in children including relationships, environment and social context (Masten and Wright, 2010; Graber et al., 2015). This area of resilience research is of continued interest as there is a growing concern about how the impact of things such as disasters, war, poverty, pandemics, and climate change influence children's health and development (Suleimany, 2022).

Race and Resilience

Children and adolescents experience normative stressors associated with development, such as peer pressure, break-ups, or academic stress. However, some ethnic minorities experience additional stressors associated with their race (Copeland-Linder, 2010). In addition to

normative life stressors, Black Americans have had to endure the trauma associated with racism, discrimination, enslavement, displacement, and oppression (Cénat, 2022; Hankerson et al., 2022). While these historical events and adversities have taken a chronic and devasting toll on Black Americans, many researchers highlight this group's survival and collective resilience (Taylor et al., 2022; Woods-Giscombe, 2023). Psychological resilience has been associated with better health outcomes among vulnerable and minoritized populations; however, emerging research also demonstrates that race-related stress can undermine resilience (Springfield et al., 2022).

Public health scholar Shervin Assari discusses the relationship between Black people and resilience through his public and academic scholarship. In his public works, he uses the sentiment "what does not kill you makes you stronger" to explain the presence of resiliency in Black people. This research suggests that Black people's experiences with structural racism have equipped them with various coping mechanisms and adaptive behaviors that helped them survive through historical hardship and oppression. Frequent exposure to stress has been linked with habituation, which may result in better adaptation to stressors (Assari & Lankarani, 2016). In theory, these experiences have made Black people more prepared to handle adversity and are less impacted by life stressors than other racial groups. A supporting study found that white men had less stressful life events, but those events had a higher impact on their mental health than Black men (Assari & Lankarani, 2016). In summary, Black people experience more life stressors but are less impacted by the potential social and psychological effects.

While Black people are exposed to more stressors, the data is conflicting on how these stressors are associated with poor mental and physical health outcomes. Additional research has supported Assari's argument that Black people are less susceptible to developing mental and

physical health problems that are derived from chronic stress (Breslau et al., 2006). Research has shown that despite their circumstances, Black people are at a lower risk for developing depression, substance abuse problems, and social and anxiety disorders. So even though Black people are exposed to higher levels of stress and adversity, their mental health outcomes are better because they have learned how to adapt (Assari & Lankarani, 2016). While these findings are positive, the association between race and mental health is complex. Much of the literature compares the mental health status of Black and White Americans because of the large gap and data availability. While prior research has shown that Black people have lower rates of depression and experience psychological distress less than other racial groups, it can be argued that there are significant discrepancies in this data. We know that Black people have developed the ability to adapt to adverse situations. Still, the ability to adapt does not have to come without health implications such as psychological distress (Williams, 2018).

Exposure to chronic stress due to racism disrupts health behaviors such as eating and sleeping. There are links between chronic stress and health disparities, especially when studying the allostatic load (Woods-Giscombe, 2023). Allostatic load measures the cumulative burden of stress and how it impacts the body (Theall et al., 2012). Allostatic load differs by race, which may explain the significant gap in health disparities between Black and White people (Schetter & Dolbier, 2011). As Assari's research notes, Black people experience more stress because of their exposure to adversity. This exposure to stress affects the stress arousal systems, impairing blood sugar and metabolism (Schetter & Dolbier, 2011; Assari & Lankarani, 2016). Furthermore, research has shown a positive association between allostatic load and cardiovascular risk in Black people (Felix et al., 2023).

A significant amount of research supports the relationship between chronic stress and health implications, but there remain discrepancies. One significant discrepancy in the data could be a lack of reporting. Studies have found that Black people may be less likely to report poor mental health outcomes. The lack of reporting could be due to the stigma associated with mental health or a lack of understanding of mental health issues (Williams et al., 2007). Continuing with the existing data, Black people have lower rates of defined psychiatric disorders across the life course than White people. However, the evidence shows that when Black people experience mental illness, it is more severe and lasts longer. Research from the National Study of American Life Supports showed that Black people have lower current and lifetime rates of Major Depressive Disorder (MDD). However, when Black and White people are diagnosed with MDD, the symptoms are more severe and often untreated in Black people (Williams et al., 2007).

Research on Black women and resiliency has demonstrated that Black women respond to stress differently than other racial groups of women (Woods-Giscome et al., 2022). Additionally, research has demonstrated that when Black women use adaptive behaviors expressed in the traditional framework of resilience, such as self-control and unwavering persistence, they experience negative health outcomes (Goodkind et al., 2020). These findings are important in furthering our understanding of how culture and race influence resilience. It challenges the traditional approach by identifying that the adaptive traits in the existing structure may not be equally beneficial to all racial groups. Other racial groups' strategies to adapt well to adversity may have negative health outcomes for Black people.

The existing research on race and resilience highlighted how historical events have shaped Black people's ability to navigate, cope with, and adapt to race-related stressors. The literature also emphasizes the importance of context and circumstance, such as neighborhood and

socio-economic status. This research is relevant because it focuses on continuous exposure to chronic stressors and adversity. A key portion of resilience research explores singular traumatic events or major traumatic events with short durations. However, Black people and other minoritized racial groups are experiencing normative life stressors and additional race-related trauma. Examining the association between resilience, race, and ongoing trauma is vital to this review as it shows how people adapt and persist through chronic and ongoing trauma and the psychosocial effects of that persistence.

Adversity, Stress, and Trauma

Resilience can be applied to various circumstances, events, and experiences. However, the literature lacks consensus about what constitutes adversity. For some, adversity could be a major traumatic event, or for others, it could be the cumulation of daily stressors. Early research on resilience disproportionately focused on single traumatic events or acute stressors. However, emerging research has pivoted to explore how people respond to ongoing trauma or chronic stressors (Schetter & Dolbier, 2011). Gottlieb (1997) described a part of chronic stress as a variety of challenges in the foreground and background of people's daily lives (Schetter & Dolbier, 2011). Homeostatic conceptualizations of resilience define resiliency as returning to prior functioning before adversity. However, research has shown that ongoing adversity, trauma, and stressors may not have a clear start or end date. Therefore, applying "returning to prior functioning" is difficult because the adversity is persistent (Schetter & Dolbier, 2011). An example of this type of adversity could be a lifelong socioeconomic disadvantage. This form of chronic stress is classified as enduring without a clear ending.

One well-researched form of ongoing adversity is community violence exposure (APA, 2008). Community violence is a critical public health concern driven by systemic racism, concentrated poverty, and limited education and healthcare access (Center for Disease Control [CDC], 2022). Community violence disproportionately affects Black youth who live in urban communities (CDC, 2022; Burrell et al., 2021). Schetter and Doblier's (2011) analysis of chronic stress uses low socioeconomic status to approach the relationship between chronic stress and health. Factors included within neighborhoods with lower socioeconomic status are unsafe conditions such as community violence (Schetter & Doblier, 2011). Characteristics of neighborhoods with community violence include crime, violence, poor housing quality, and drug sales (Foell et al., 2022). Various adverse social, behavioral, and physical health outcomes are associated with community violence exposure. Notably, the relationship between community violence exposure and mental health is clear: there are positive associations between CVE and an increase in symptoms such as depression, anxiety, and aggression (McDonald, 2008).

Many understandings of resilience involve rebounding from tragedy/trauma or returning to pre-crisis status (Woods-Giscombe, 2023; Schetter & Dolbier, 2011). These understandings can be challenging to apply to the context of community violence. People who live in neighborhoods with high rates of community violence are not attempting to recover from one isolated event but rather a series of traumatic events, which makes the application of resilience more complex (Cooley-Quille et al., 2001).

If resilience is defined as the ability to adapt well after experiencing adversity, what does it mean to adapt well in the midst of continuous exposure to community violence? A study on resiliency in Black youth exposed to community violence shifts the traditional framework of resilience by demonstrating how the pre-existing model of resilience does not apply in instances

of severe and continuous trauma. Woods-Jaeger (2020) developed a contextually relevant understanding of resilience to fit the unique circumstances of individuals exposed to disproportionate levels of community violence. This new approach tailors concepts within the traditional framework of resilience by recognizing how certain traits, responses, and mechanisms may surface differently. One major difference is the variations in coping mechanisms.

Coping Mechanisms and Resilience

Extensive research has examined the relationship between coping mechanisms and resilience. These two constructs are related but have different impacts on behavioral changes (Wu et al., 2020). Resilience is the capacity to recover from adversity, and coping mechanisms are strategies for handling and navigating adversity (Wu et al., 2020). There are various coping mechanisms that an individual can employ to manage a stressor. Racial and cultural differences exist in how people respond to s (Woods-Giscombe, 2023; Woods-Jaeger et al., 2020).

Research notes that protective factors can influence healthy coping behaviors. Since resilience is the adaptive process of how individuals respond to adversity while considering the interaction of context and environment, it is essential to note what protective factors individuals have to aid in healthy coping and mitigate the impact of trauma (APA, 2008; Linder-Copeland et al., 2010). Characteristics of protective factors in a neighborhood could include quality schools, resources, support, and nonviolence (APA, 2008).

The development of resilience research has shown that positive adaptation extends outside of the capacity of the individual and relies on factors such as community, environment, and culture (Fleming & Ledogar, 2008). In the conventional model of resilience, certain factors and behaviors have been shown to aid in the resilience process. Further research has shown that

the maladaptive/adaptive categorization of coping shifts based on contexts. A study on emotional flexibility explored this notion by examining how emotional suppression and expression can be helpful and harmful. Typically, emotional expression is encouraged, and emotional suppression is discouraged. However, there are instances where emotional expression can be harmful (Bonanno et al., 2004). A 2004 study demonstrated the importance of flexibility of emotional expression, documenting that it is advantageous to have the capacity to express and suppress emotions situationally. The results highlighted that people who foster emotional flexibility have the best long-term adjustment (Bonanno et al., 2004). This study and the research grounded in emotional flexibility suggest that coping mechanisms and emotional responses are situational. It is not always accurate to label one response maladaptive or adaptive because it varies by context.

Repressive copers will not report feelings of distress in stressful situations. This emotional disassociation is associated with long-term health complications (Mancini & Bonanno, 2009). However, as the previous example explained, flexibility is vital. Repressive coping can equally fall in the category of adaptive coping because it is a person's automatic response to avoid threatening stimuli. Repressive coping is similar to emotional suppression but more advanced. With repression, individuals are to mitigate potentially overwhelming and threatening experiences. Although traditionally seen as a maladaptive coping mechanism, repressive copers have employed active problem-solving strategies instead of coping mechanisms motivated by emotion (Mancini & Bonanno, 2009).

Woods-Jaeger (2020) argues that certain behaviors that may seem maladaptive are adaptive and are necessary to adopt resilience in these traumatic circumstances. For example, fearlessness and emotional suppression are typically regarded as maladaptive coping responses. Still, for youth in environments with high rates of violence, these behaviors are coping

mechanisms, and evidence has shown that these behaviors have been helpful (Woods-Jaeger et al., 2020). The seemingly maladaptive mechanisms are often adopted without resources and formal support. Research on resiliency and community violence has shown that the greatest way to help youth mitigate the risk of environmental stressors is by addressing community problems through programs and opportunities to heal from trauma. A supportive social network and environment are advantageous to helping people respond constructively to community violence (Tyson McCrea et al., 2018).

The aforementioned literature on resilience, race, and community violence explores the emergence of resilience research, which is beginning to include more examinations of the interaction between culture and context. This opening literature laid the foundation for how Black people have processed and persisted alongside chronic stressors. This literature supports this dissertation study of how Black youth respond and adapt to the ongoing trauma from community violence exposure.

While a pivotal piece of this research involves the study of resilience, it is intended to explore how youth challenge and defy some of the traditional understandings of resilience through three papers. The overall research question examined is how youth utilize survival techniques, coping mechanisms, and adaptive behaviors to navigate and respond to community violence exposure. Furthermore, this project explores how youth use these behaviors to aid in the process of resilience.

The first paper in this dissertation illustrates how Black youth and trauma clinicians view resilience and the adaptive process of living in an environment with ongoing trauma. Through this chapter, youth and clinicians share more about the complex nature of community violence and the mechanisms youth must use to survive. I show how survival techniques and coping

behaviors are used in tandem for youths' resilience. I also argue that the adaptive process to recover from trauma often mimics survival and not resilience.

In the second paper, youth and clinicians explore coping mechanisms and behaviors that have helped youth navigate community violence exposure by primarily focusing on behaviors that helped youth feel better and maintain their safety. In this paper, I provide deeper insight into the function of these mechanisms and how many maladaptive coping mechanisms have adaptive components due to the nature of community violence exposure. In this chapter, I also present additional coping mechanisms that youth use that may be overlooked or understudied.

In the last paper, I align youth needs with clinicians' expectations of what they believe youth need to help them cope with community violence. I reveal many similarities between the youth and clinicians, specifically related to ensuring youths' basic needs are met in addition to receiving trauma recovery care. Furthermore, this chapter provides suggestions and recommendations from youth and clinicians on what improvements can be made, specifically concerning trauma treatment and clinician training.

Research Site

Violence is a critical public health issue that is increasingly apparent in many major US cities. Chicago is of particular concern due to its prevalence of gun violence and heightened appearance in public media (Fitzpatrick et al., 2016). Violence in Chicago has been a longstanding issue, often attributed to the association of socioeconomic factors and structural inequities.

The effects of violence disproportionately impact Black people and youth. A 2017 report by Ann and Robert H Lurie Children's Hospital of Chicago (2021) showed that Black youth in

Chicago were 13.7% more likely to die due to gun violence compared to other non-Black youth (Ellyin et al., 2021). The city has seen periodic spikes in violent crime (Ellyin et al., 2021). A historical spike occurred between 2015 and 2016, with a 58% increase in homicides and a 42% increase in non-fatal shootings (Kaputsin et al., 2017). Over the past three years, Chicago has averaged 4,106 shootings and 797 homicides annually, with violence most concentrated in the city's South and West sides.

There are various theories and policies that attempt to explain Chicago's history of gun violence and surge in homicide (Kaputsin et al., 2017). While there is a lot of research focused on the causation of this spike, a great deal of research has also been concentrated on responding to this surge in violence through violence prevention, intervention, and trauma recovery.

The University of Chicago Medical Center (UCM) Recovery & Empowerment After Community Trauma (REACT) a community violence trauma recovery program, was founded to address and respond to the unmet needs of youth who are disproportionately affected by community violence.

Additionally, REACT offers an innovative assessment clinic that provides interdisciplinary care for pediatric patients exposed to community violence. Led by clinical psychologists and medical doctors, it provides brief, culturally responsive psychiatric assessments. Patients receive psychological screening, education, and support, followed by comprehensive psychiatric evaluations over two sessions. Patients and their families may also receive tools, resources, and recommendations for long-term treatment, which may involve coping strategies, therapy, or medication. The REACT recommendations are anti-racist, structurally competent, and culturally responsive. Since 2016, the UCM REACT Program has served at least 1,500 children and families with screening, support, and psychoeducation,

evidence-based trauma-informed ongoing individual and/or family therapy, and psychiatric services.

The REACT clinic serves patients aged 0 to 24, predominantly Black youth from the west and south sides of Chicago, many of whom have been directly or indirectly exposed to gun violence and other traumatic events. During 2021- 2022, the REACT Program provided trauma-informed services to 527 CV-affected individuals. One-fourth were children 0-12 years old.

The REACT clinic notes that various other forms of trauma and adversity are present in their patients, such as sexual abuse, housing instability, and housing insecurity.

Additionally, the program is designed to address the clinical needs of patients while fulfilling clinicians' training requirements. Operating as a training clinic, REACT prepares clinicians to effectively deliver trauma-informed care to underserved urban populations

The REACT clinic also provides some support for the parents/caregivers because they also have often had some exposure to community violence. The clinic takes a communal and family approach to care by ensuring its recommendations are accessible, feasible, and culturally responsive. To evaluate the REACT clinic's effectiveness, quality, and feasibility, in 2022, the clinic began a systematic investigation into the REACT clinic model to find ways their model can be improved to help future families.

Recruitment

Participants in this study were recruited from the REACT program. I contacted eight clinicians, and two declined to participate, with 6 completed interviews. For youth participants, I contacted 30 youth participants with nine completed interviews. Of those 30 youth, eight originally agreed but either did not attend the interview or canceled, often due to a family emergency or life crisis. For example, one participant was incarcerated at the time of the

interview. I followed up with three rescheduling attempts for the youth who needed to reschedule. The remaining 13 participants did not respond or have updated contact information.

Most of the 9 youth participants frequently participated in other research studies at the clinic and liked to provide feedback on various aspects of the clinic. Many of the participants who had to reschedule or cancel often had conflicting priorities and did not have the availability to participate. In general, it was challenging to contact many families due to scheduling conflicts and constant changes in contact information. The challenges associated with this recruitment are similar to the REACT clinic's challenges with recruitment for other research studies with families in active crisis or stressful circumstances.

Participant Demographic Information and Sample

This sample consists of six clinicians and nine youth participants recruited from the REACT Clinic. Each participant was assigned a pseudonym for confidentiality, and the clinicians all have *Dr.* before their names to distinguish them from the youth participants in the findings section.

This sample included two clinical psychology interns, two clinical psychologists, one post-doctoral fellow in clinical psychology, and one mental health counselor. Five female clinicians and one male clinician participated. Of the six clinicians, four identified as Black, one as White, and one as Latino.

The youth participant sample consists of six male and three female participants between the ages of 15 and 20. All of the male participants in this sample reported having been physically harmed due to community violence, and all the female participants reported witnessing violence or losing a loved one to violence.

Table 1: Clinician Demographics

Pseudonym	**Sex**	**Category**
Dr. Mario	Male	Intern
Dr. Brianna	Female	Post-Doctoral Fellow
Dr. Gina	Female	Mental Health Counselor/Social Worker
Dr. Amanda	Female	Clinical Psychologist
Dr. Nicole	Female	Clinical Psychologist
Dr. Rebecca	Female	Intern

Table 2: Youth Participant Demographics

Pseudonyms	**Age**	**Sex**	**Physically Harmed**
Miles	18	Male	Y
Cameron	19	Male	Y
Kyla	15	Female	N
Trey	20	Male	Y
Mya	20	Female	N
Jaylen	20	Male	N
Dana	15	Female	Y
Justin	16	Male	N
Jordan	16	Male	N

Overview of Research Design & Methods

After obtaining IRB approval from the University of Chicago, participants for this study were recruited from a community violence intervention program and clinic through the University of Chicago Hospital. The REACT program provides families with brief trauma-focused intervention and access to psychological and psychiatric care and ongoing therapy. The program supports people who have been affected by community violence, whether or not they have been physically injured.

The first phase of data collection semi-structured interviews. This interview style aims to create an open discussion between the participant and the interviewer. Participants were asked a

series of questions to understand their experiences with community violence and coping. Interviews were held via Zoom. Before each interview, participants and/or their parent/guardian (for participants under 18) were given a consent/assent form that had to be signed before the interview. The participants could pause the interview, skip questions, or withdraw from the study without penalty. Participants were also informed that the interviews were audio-recorded, and their confidentiality was protected. There were two groups of participants:

> ***Youth Participants:*** Former and current REACT patients and participants ages 15-20. These interviews aimed not to ask detailed questions about their traumatic experiences but about how they have attempted to "recover," cope, and navigate life with their experiences with community violence exposure and complex trauma. Questions for this interview were developed from a combination of similar research studies and the Connor-Davidson Resilience Scale (CD-RISC2). Adolescent interviews lasted approximately between 60-90 minutes. Each participant received a $25 e-gift card for their participation.
>
> ***Clinician Participants:*** Former and current clinicians at the REACT Clinic. The clinicians' role was to provide a broader applied psychological understanding of resilience, survival, and coping from the perspective of a clinician at the REACT Clinic. Clinician interviews will last 45 minutes to an hour. Each clinician will receive a $25 e-gift card for their participation.

The second phase of data collection was adolescent focus groups. The focus groups were to share and discuss experiences with navigating community violence with other adolescents. Participants from the first phase were invited to participate in a 90-minute focus group with other

REACT participants. The focus groups were held via zoom. Before each interview, participants and their parent/guardian (for participants under 18) were given a consent/assent form that had to be signed before starting the focus group. Each participant received a $20 e-gift card for their participation.

Coding and Analysis

Interviews and focus group data were coded using Dedoose software. The focus was on identifying how youth respond to community violence exposure by examining trauma responses, coping behaviors, and survival techniques. This method allowed the research team to uncover connections and themes from the data. The interviews were used to identify how youth are processing their trauma and what daily adaptations they are making from the perspective of youth and trauma recovery clinicians.

The coding process is guided by Saldaña (2013). The analysis began with deductive coding, which involved broadly sorting the data into topical categories based on the concepts within the research questions and the interview protocol. Later in the coding cycle, two evaluators conducted inductive coding to develop themes and findings and identify patterns across the interviews and the focus group. With inductive coding, the codes are derived from themes in the data. A codebook was generated to highlight the most prevalent themes from the interviews and the focus group. All research team members reviewed and provided feedback to finalize the codebook. This coding process involved a combination of inductive and deductive coding, starting with a set of codes based on the categories of the research questions interview protocol and then creating new codes and sub-codes through a deeper analysis with inductive coding.

Positionality Statement

In 2022, I began my role as the study coordinator at the REACT clinic to help lead their assessment and evaluation of the clinic's treatment model. In this role, I managed and conducted research projects within the clinic. My primary project was the feasibility study to examine and synthesize formal feedback from patients, their caregivers, and clinicians to identify and understand opportunities to improve the REACT clinic and to inform the best practices and policies to effectively support families affected by community violence in a pediatric medical setting.

In my position, I conducted focus groups, administered surveys, and hosted community advisory board meetings. Part of my role was leading research recruitment, which required me to contact families frequently. These extensive interactions with patients and clinicians led to me creating close relationships with many families. Often, families would confuse me for a clinician or social worker due to my connection with other clinical staff. Clinicians and families would also often mention my caring and empathetic nature as additional reasons families would develop close relationships with me. A few times, families would call me in emergency cases or crises, and I would connect them to the proper people and resources. Additionally, because of the diverse needs of many families in the REACT clinic, I would often assist with other needs, such as employment opportunities or literacy needs. Some of the youth participants and clinicians interviewed for this dissertation I met through my role at the REACT clinic. While the dissertation and feasibility studies are separate projects, my relationship with the clinic helped give study participants a sense of familiarity and comfort because of my role at the clinic.

CHAPTER ONE: UNDERSTANDING RESILIENCE AMONG BLACK YOUTH

Resilience, extensively studied to comprehend the psychological, social, and emotional factors enabling individuals to bounce back and thrive despite challenging circumstances (Tugade & Fredrickson, 2004), has often been limited to understanding how individuals overcome stress and adversity. However, this process is influenced by diverse individual and contextual factors (Kirmayer et al., 2012; Southwick et al., 2014; Nugent et al., 2014). Human responses to stress and adversity involve a complex interplay of internal characteristics and external factors (Sisto et al., 2019). Interactions with others, access to resources, and community support significantly shape stress and trauma responses, ultimately impacting an individual's ability to cope and recover (Southwick et al., 2014). Resilience research on children is pivotal in understanding how individuals navigate trauma and adversity (Masten & Barnes, 2018). Support from family, friends, and the community is associated with reduced aggression and delinquency in youth (Jain & Cohen, 2013).

Environment plays a crucial role in shaping an individual's resilience. Emerging literature emphasizes this influence because initially, resilience was viewed as a set trait instead of an adaptive process (Kirmayer et al., 2012). Because resilience is an adaptive process, it often involves mechanisms, resources, and support systems to aid in individuals' ability to recover from trauma and adversity (Fleming & Ledogar, 2008). People's access to resources and forms of support also varies depending on their environment or context, thereby influencing how they adapt to trauma and adversity.

Furthermore, the degree of trauma and adversity experienced by individuals is also contingent upon their surrounding circumstances and environment (Matheson et al., 2020). Some people experience multiple forms of trauma and adversity concurrently or over an extended

period. This variation also greatly influences a person's ability to bounce back because they are attempting to recover from multiple incidences of adversity (Steinhardt, 2010). While “bouncing back” or returning to pre-crisis status is an essential component of many applications of resilience, resilience may also include developing coping and adaptive skills to help deal with adversity (Assari & Lankarani, 2016; Tugade & Fredrickson, 2004).

Recognizing how resilience and recovery may differ based on context makes the relationship between resiliency and community violence exposure particularly important (Woods-Jaeger et al., 2020). Exposure to structural and community violence can have significant negative impacts on social, behavioral, and physical health throughout the lifespan. Research indicates that community violence particularly affects the health and development of youth, with Black youth being disproportionately impacted (Boyd et al., 2022; Foell, 2021).

Emerging research explores resilience and community violence exposure primarily because resiliency and associated characteristics are often promoted in these contexts (Woods-Jaeger et al., 2020). Resilience in the presence of community violence exposure has been defined as “a dynamic process of transactions within and among multiple levels of children’s environment over time that influences their capacity to successfully adapt and function despite experiencing chronic stress and adversity (Woods-Jaeger et al., 2020). This definition provides additional context to the study of resilience but does not fully encompass the nuances and unique experiences of Black youth's navigation of community violence exposure.

Primary critiques of resilience focus on the individualistic approach. This approach is problematic because it eliminates the influence of social and cultural contexts and how they may aid in this adaptive process (Kimaryer et al., 2012). Research on resiliency and community violence has shown the greatest way to help youth mitigate the risk of environmental stressors is

by addressing community problems through programs and opportunities to heal from trauma. A supportive social network and environment helps people respond constructively to community violence (Tyson McCrea et al., 2018).

A more contextually relevant understanding of resilience in Black youth exposed to community violence requires a closer understanding of those youth's experiences and of trauma clinicians who work with them. This chapter explores how youth living in communities with community violence challenge and defy the traditional framework of resilience by exploring their protective factors, trauma responses, coping mechanisms, and survival techniques.

Literature

Although there is no uniform definition of resilience, it is generally defined as an adaptive process encompassing an individual's response and recovery from various challenges, including trauma, tragedy, and stress (Southwick et al., 2014). While much attention is given to individual traits that facilitate resilience, it is crucial to recognize that resilience is multidimensional and influenced by the dynamic interactions of biological, psychological, social, and cultural factors (Southwick et al., 2014)

There is a growing emphasis on exploring resilience within marginalized groups, shedding light on cultural factors and how individuals facing systemic barriers demonstrate remarkable resilience in adverse circumstances (Ungar, 2008). Research has indicated that there must be unique approaches to trauma treatment, particularly for highly traumatized and ethnic minority groups that focus on techniques that address somatization and physical flexibility (Hoskins et al., 2018). Somatization, the physical expression of emotional distress, is of importance, particularly in Black and Latino communities, because research has suggested that

these groups often express stress through somatic symptoms (Scott & McCoy, 2018; Hoskins, 2018). Black and Latino communities are also at higher risk for engaging in unhealthy behaviors as a means to cope with the trauma associated with violence (Byrd, 2023).

Understanding resilience as a dynamic process influenced by individual and environmental factors is crucial for developing effective interventions and support systems (Zimmerman, 2013). By recognizing the interplay between internal characteristics and external influences, researchers and practitioners can better support individuals and communities in navigating and overcoming adversity (Southwick et al., 2014; Zimmerman, 2013).

Trauma Responses

Trauma affects everyone differently, and each individual's immediate and delayed responses to trauma vary depending on their experiences and contextual factors such as access to resources and social support. Trauma responses can occur across various domains, including emotional, physical, cognitive, behavioral, social, and developmental (SAMHSA, 2014). These responses are typically expected to be immediate and resolved without severe long-term consequences. However, trauma researchers recognize that the severity and duration of exposure to trauma alters the trauma response (Lynn-Whaley & Sugarmann, 2017). For individuals who have experienced multiple traumas or prolonged traumatic experiences, their trauma responses are similar to people who have experienced an isolated traumatic situation, but they have different characteristics (SAMHSA, 2014).

According to the National Child Traumatic Stress Network (2017), complex trauma often has significant implications on children's development and ability to form attachments. Children who have experienced complex trauma can display a wide array of trauma responses, including

emotional and body dysregulation, meaning they over or under-respond to stimuli. They are often vigilant and guarded and see most interactions as stressful or dangerous. In these cases, people are unable to recognize that the conditioned stimuli do not signal a threat (National Child Traumatic Stress Network [NCTSN], 2017; Lynn-Whaley & Sugarmann, 2017). Under the fear conditional model, people can utilize extinction learning, which describes the successful adaptation to trauma. Within extinction learning, people will develop the ability to recognize conditioned stimuli without an aversive outcome (Bryant, 2021). For example, if a person is involved in a shooting, they may have stress responses related to stimuli such as long noises and crowds of yelling. Outside of this event, this person may be exposed to similar stimuli, but remember that they are not in danger and will eventually adapt to the traumatic experience (Bryant, 2021).

Prolonged exposure to trauma creates a sustained activation of stress, also known as toxic stress. This form of stress is a maladaptive stress response that can have potentially severe consequences, including an impact on brain development (Substance Abuse and Mental Health Services Administration [SAMSHA], 2014); Lynn-Whaley & Sugarmann, 2017; Nelson et al., 2020). Toxic stress contributes to adverse social and health outcomes, particularly within communities affected by high levels of crime and gun violence, where toxic stress can be pervasive (Lynn-Whaley & Sugarmann, 2017). Furthermore, exposure to toxic stress can result in the disruption of brain and body development, potentially increasing the risk for mental and physical disorders (Nelson et al., 2020).

Community Violence and Trauma

Community violence is of particular interest because this form of exposure can be complex. For individuals who live in neighborhoods with elevated rates of violence, this is an ongoing trauma that can last for an extended period (Lynn-Whaley & Sugarmann, 2017). Research on poly victimization shows that youth who are victimized by violence once are more likely to be repeatedly victimized by violence. Depending on the context, people can witness and experience violence daily (Foster et al., 2004; Finkelhor et al., 2007; Dubé et al., 2018; Jones, 2007).

Community violence exposure is a type of trauma that can be witnessed, learned about, or directly experienced (Lynn-Whaley & Sugarmann, 2017). Previous research demonstrates that community violence exposure presents a significant risk for maladaptive development in children and their caregivers (Cooley-Strickland, 2009; Osofsky, 1995; Scheeringa & Zeanah, 1995). A 2015 study on coping in pregnant women found that the experiences of trauma in childhood can lead to maladaptive coping mechanisms in adulthood (Choi, 2015). These findings are relevant because they emphasize the relationship between childhood trauma and health in adulthood and its influence on intergenerational trauma (Choi, 2015; Matheson et al., 2020).

Violence exposure also has social implications. A 2014 study on community violence exposure in childhood found that children and adolescents exposed to violence and physical abuse were less likely to expect to survive to age 35. This low expectation for survival places youth at a greater risk for detrimental behaviors that can affect their well-being (Warner & Swisher, 2014).

Research has also shown that health and development can be impacted even if individuals are not directly exposed. Being a victim or a witness is both associated with psychological distress (Dubé et al., 2018). A 2023 study on community violence exposure in emerging adults

found that individuals' direct exposure to community violence was related to high levels of emotional dysregulation, anger, and post-traumatic stress symptoms. Similarly, witnessing community violence was associated with emotional dysregulation and resilience (Wamser-Nanney et al., 2023). These findings align with earlier research on community violence and development, which states that community violence exposure may affect children's development, self-regulation, and behavioral control, which is supported by the literature on social information processing (Cooley-Strickland, 2009; Dodge & Pettit, 2003).

The impact of community violence on learning and development manifests in several ways. Community violence can affect academic performance, educational and career aspirations, challenges in forming trusting relationships, and impaired development of the prefrontal cortex. Most notably, it can also heighten the difficulty of distinguishing between threat and safety (Cooley-Strickland, 2009). Because of the environment, youth also have limited opportunities to interact appropriately with their peers and to develop positive social experiences (Dubé et al., 2018). The limited social interactions and bonds with peers explain how and why youth learn and adopt violent behaviors (Ostrov, 2010; Dubé et al., 2018). Positive peer relationships are important, and developing these relationships increases the odds of positive behavioral adaptations to trauma (Jain & Cohen, 2013).

In a 2009 longitudinal study on behavioral adaptation in youth exposed to community violence, researchers found that the participants in the study displayed a normal or better range of behavioral problems over time, especially 2–3 years after exposure. This finding aligns with other longitudinal research on trauma and resilience (Jain & Cohen, 2013). Research has shown that because of youths' exposure to ongoing trauma, they learn how to make adaptations to ever-present threats. Many models attempt to describe the process of adapting to trauma, but a

significant challenge is recognizing that threats can occur concurrently or sequentially, which can affect long-term adaptation (Silove, 2013). Furthermore, there are gaps in longitudinal research that examine pre- and post-event behaviors and adaptations (Linley, 2003). In a 2023 study on coping with community violence, the findings suggest that young Black and Latino men have to learn survival skills and adapt to new ways of living because of their exposure to community violence. This finding is significant because the need to learn how to survive and cope with their current circumstances aligns with the literature on males suppressing their emotions (Byrd, 2023).

Emotional suppression and desensitization are behaviors often adapted after exposure to community violence. It appears to be adaptive in the short-term for decreasing depressive symptoms but may place youth at elevated risk for callousness, violence perpetration, and additional violence exposure if it becomes habitual (Gaylord-Harden et al., 2017). The problem with emotional desensitization and similar adaptive behaviors is that they can be helpful in the short term but pose a series of severe consequences in the long term. Research has shown that these adaptive behaviors are no longer helpful and interfere with their living ability (NCTSN, 2017). In a longitudinal study, researchers found that youth who have high levels of community violence exposure utilize emotional desensitization as a protective factor that may limit violent behaviors in the future. This study also showed that youth with low exposure to community violence had increased violent behavior in late adolescence (Gaylord-Harden et al., 2017).

Resilience and positive adaptations are of great interest in youth because some theories suggest that as youth are exposed to trauma, they also develop stress responses and protective hormonal and epigenetic changes. While youth and adults continue to develop adaptation to stress, researchers have noted that this process is also related to environmental stressors and

positive environmental change (Rogers & Lucchesi, 2014). A 2023 study on positive adaptations looked at adaptation in youth in a residential facility. From the findings, the participants deemed resilient also had the most protective factors, including assets and resources (Solva, 2023). A similar study investigating youths' experiences with community violence found that youth living in neighborhoods with increased cohesion had lower levels of positive behavioral adaptations. One explanation for this counterintuitive finding is that although the neighborhood may be cohesive, there may be negative social norms that promote poor adaptations to violence and trauma (Jain & Cohen, 2013). This finding corroborates the aforementioned research on the role of environment and context and how it influences adaptations and resilience in youth.

The literature is lacking in thorough assessments of the interaction between social settings and the environment and how these dynamics influence responses and recovery, particularly in the context of community violence. While trauma responses are well documented, the literature also lacks an explanation of how repeated exposure to trauma often prompts the promotion of adaptations that may seem maladaptive but are contextually adaptive and essential in ensuring survival. Therefore, in this chapter, I explore how youth process and respond to their exposure to trauma through survival mechanisms. I also examine how what the literature describes as temporary trauma responses have become survival mechanisms and adaptations to trauma.

Methods

Participants for this study were recruited from REACT, a community violence trauma recovery program. Part of this program is the REACT clinic, an interdisciplinary clinic providing trauma-focused interventions and psychological and psychiatric support to families impacted by

community violence.

Six clinicians and nine youth participants were recruited from the REACT Clinic. Five of the clinicians were female, and one was male. Six youth participants were male, and three were female, ages 15 to 20. All three of the female participants had witnessed community violence and experienced indirect physical harm. All six of the male participants had witnessed community violence and experienced direct physical harm. More details about the participants can be found in the introduction chapter.

The data analyzed for this chapter explores clinician and client responses to open-ended questions related to community violence, resilience, and survival through semi-structured interviews and a focus group. These questions aimed to reveal patients' and clinicians' perspectives on the concept and process of resilience and how exposure to community violence can shift their understanding of the concept.

The introduction chapter provides the complete methods and analysis for this study. The first phase of data collection was semi-structured interviews. Before each interview, participants and/or their parent/guardian (for participants under 18) were given a consent/assent form to sign. Participants were also informed that the interviews were audio-recorded, and their confidentiality was protected.

The section of the youth interview analyzed for this chapter asked youth questions about their understanding of resilience, survival techniques, and adapted behaviors. The specific questions were:

1) Have you ever heard of the word resilience? If so, what does resilience mean to you?
2) Do you think resilience is positive or negative?
3) How are you adapting to your experiences with community violence?
    a. Are there behaviors that you have adopted because of community violence to survive?

The section of the clinician interview that was analyzed for this chapter asked them to describe their understanding and exemplification of resilience in their patients, as well as survival techniques and adapted behaviors youth utilize. The specific questions were:

1) What are some of the most common ways you see community violence affecting your patients?
2) How do you define resilience?
    a) How do you feel about the word resilience?
    b) Do you call your patients resilient? Why/why not?
    c) How does resilience manifest in the presence of CVE and complex trauma?
    d) In what ways have you recognized your patients attempting to adapt to CVE?

The second phase of data collection was youth focus groups. In this part of the study, youth participants collectively discussed major themes derived from the semi-structured interviews.

Coding and Analysis

This analysis incorporated both inductive and deductive coding. Starting with deductive coding, the data was sorted into broad topical categories based on the concepts within the research questions and the interview protocol. Primarily focusing on concepts such as resilience, coping, adapting, and surviving.

Later in the coding cycle, two evaluators conducted inductive coding to develop themes and findings and identify patterns across the interviews and the focus group. A codebook was generated to highlight the most prevalent themes from the interviews and the focus group. All members of the research team reviewed and provided feedback to finalize the codebook. The prevalence of each theme and subtheme was assessed across the interviews. Selected subthemes from this chapter are listed in Table 1.

Table 3: Subthemes and Example Quotes on Resilience

Subthemes	Examples Quotes
Clinician Understanding of Resilience	"Resilience is just moving forward and knowing that you're unstoppable with all the resources that you have at your fingertips?"- Dr. Gina "The ability to overcome stress and adversity. I strongly dislike it because I feel like everyone doesn't have the same access to do things in the face of stress and trauma and adversity."- Dr. Amanda
Youth Understanding of Resilience	"In this book, this girl had seen her family get killed and then it was like, how she struggled to get to where she was, and she was a millionaire in the end." - Dana "[Resilience] it means strong"- Cameron
Opposite of Resilience	"The opposite looks like the kids around the city purging during the purge. When I came up, we had Mayor's Office City of Chicago programs, and so we had opportunities to leave school and do work. But the opposite spectrum looks like them." Clinician Gina "I don't know, like, for one, he was gang related. So, we obviously have differences. And I wouldn't want to say he failed. But like, I felt as though he wasn't resilient."- Trey
Survival Techniques	"If survival techniques are like things I have to do to stay where I'm at, like, just stay alive. - Dr. Nicole "Survival techniques: number one, staying in the house. I'm taking different routes around the community. I know a lot of my patients who have gotten back into their communities. If I was not able to get them moved to a family member's house or an emergency move, they would have to leave the hospital late at night and go back into the communities in the dark, so they wouldn't be seen or go through the back ways, you know. And then staying in the house. - Dr. Gina
Survival Techniques into Adapted Behaviors	"If your environment isn't changing thereafter, so you got me, your therapist, talking to you about being hyper-vigilant and the stress and strain from being aroused all the time. So, you have your heart rate up, but it is when the world that you exist in on a day-to-day basis is potentially threatening all the time, you're ready to go. You are ready to fight. You know, you're ready to protect yourself. That's adapting. Thats coping too." - Dr. Brianna "When I think about resilience, I think about succeeding and thriving, in addition to surviving, so I think with adapting, it's like, you're kind of just taking things as they are." - Dr. Mario

Results

Throughout interviews, clinicians expressed challenges in their attempts to define and describe various concepts associated with resilience. Clinicians experienced divergence between their clinical training and their evolving perspectives through their applied work. Moreover, clinicians found the exercise demanding due to the nuanced nature of certain actions or behaviors of youth, which can assume multiple meanings depending on context and function. Exemplifying this sentiment, one clinician states:

> I don't know. It all gets really confused in my head. Because none of these definitions are clear. Nor do I know if they totally apply to community violence, right? Like they all kind of muddle in some ways. – Dr. Amanda

Most of the clinicians stated they did not like the word resilience and would not use it to describe their patients directly. One clinician, Nicole, also expressed her dislike for the word but described it as "having hope in action." Clinicians dislike had less to do with the internal characteristics incorporated within resilience but with the implications of being labeled resilient:

> My understanding of resilience: I don't like the word resilience. My field loves it. White psychology loves the construct of resilience. To me, it means making do with an unjust life, surviving being here, and appearing whole in the context of injustice. - Dr. Briana

Many of the youth had heard of the word resilience but never used it to reference their experiences. Jaylen, a former patient in the clinic who was shot before his senior year of high school, expressed that although he was in a lot of pain and struggling to adapt to his life after the shooting, he still attended school. Because of this, Jaylen received a resilience award. It was the first time someone had ever called him resilient. When I asked Jaylen how he felt about the award, he explained how the award was a lot of pressure. He felt that because he was being

labeled as resilient, that people assumed that he was "okay". Jaylen expressed he was still struggling greatly and was having breakdowns while people were calling him resilient:

> Sometimes I feel like it's a lot of pressure. Because I get called many things, but at times I know I break down a lot. It's kind of like being a leader of something like a group and let them see that you're weak or that there's something that's affecting you, and it's just like so much pressure for me. People will say "Oh man, Jaylen hardbody this ain't nothing for him, he's straight" but when I'm by myself its like, Am I really? Yeah, I know what it is. I survived and things of that nature, but it's the after-effect. It's not the day of, it's the days after. - Jaylen 20 y/o Male

The notion that this participant is describing aligns with the reasons the clinicians did not like this term. Resilience is often used as an endpoint and not a process. People are labeled as resilient; therefore, the assumption is that they do not need support and that once you reach the status of resilience, you are healed. But as this participant describes his recovery journey, he experienced a lot of emotional and physical ups and downs while still being required to do normal things like attend school. Jaylen expressed that he was surprised when he received the resilience award at school. He states he did not know he was resilient, "I didn't think I was [resilient]. I thought I was just being me."

Some participants had heard of the word resilience and embraced their understanding of its meaning. For Miles he associated resilience with being strong, and he expressed he is resilient because:

> I went through that traumatic event. You know, still try to act happy. I get up every morning and dust myself off - Miles, 19 y/o male

While he identified with this definition, similarly to Jaylen, Miles recognized that resilience can be associated with certain expectations to maintain a status of being strong. Miles expresses that resilience can be a good and bad thing:

> It's good because it's giving me the push to want to do better. But at the same time, I can be too hard on myself."- Miles, 19 y/o male

Youth describing the expectation to be "okay" and to push themselves harder during adverse experiences further aligns with clinicians' dislike for the concept of resilience. Through the interviews, clinicians often described the psychological implications associated with youths' embodiment of resilience.

Sometimes Resilience is Just Surviving

Clinicians had varied ideas of what resilience looks like in the presence of community violence exposure. In their interviews, clinicians described attributes, behaviors, and characteristics they would typically associate with resilience; however, in this context, many clinicians stated that surviving is resilience:

> I think kids just able to survive as a big win. Unfortunately, it's sad to say, but kids being able to survive these environments is resilience. – Dr. Mario

> When you ask that question, it's hard because sometimes surviving is resilience. Sometimes it is just breathing, being alive. – Dr. Brianna

Surviving and survival techniques were frequently discussed in youth and clinician interviews. Both groups discussed how the use of consistent survival techniques was essential to surviving and how it was a significant component of resilience. From the discussions, the idea of survival techniques emerged as actions and behaviors that people use immediately to survive. They are the instant reactions to a situation. A clinician described survival techniques as:

> Things that you have to employ right away that are linked with high levels of distress because your body is telling you that you need to do this, or you might die. So, it's not

> ideal that kids have to do this more often than not because survival tactics are very distressing. - Dr. Mario

Youth participant's view of survival techniques aligned with clinicians. They were thought of as actions and behaviors you need to survive. Staying inside or at home was a commonly noted survival technique to maintain safety and avoid violence. When patients did leave the house, they had a separate list of techniques to help them survive. One patient stated his survival technique is:

> Don't be outside after six because it doesn't serve me. Well don't be outside after the streetlights come on before it gets too late. - Miles 18 y/o male

Another youth also discussed the importance of navigating outside and not staying out late. He described his survival technique as moving like the president. He explains:

> Just don't stay out too late. You know, you got to play your part. Know if somebody's looking for you, you shouldn't be walking outside like a regular civilian. If you want to survive, you got to move like hey, nobody can touch you. I'm saying like a president or something. - Cameron 19 y/o male

Many patients highlighted smoking marijuana as a means of survival. Among the patients in this study, the dominant method reported for coping was the use of marijuana. Clinicians similarly identified smoking marijuana as a frequently employed coping strategy. A lot of patients smoked before their exposure to community violence, but the use increased after exposure to violence. While a deeper exploration of smoking marijuana as a coping mechanism will be explored in Chapter Three, in this chapter, smoking is depicted as instrumental in allowing youth participants to leave their homes. It is often characterized by their definition as a survival technique.

Through the clinician interviews, there was a lot of discussion on the similarities and overlap between adapting, coping, and surviving. One patient described his survival technique as "always being careful and cautious." However, the immediacy of survival techniques was not always viewed the same by patients and clinicians. Patients viewed survival techniques as things needed to survive. For example, a patient preferred staying in the house but needed to leave

home to work. Therefore, she felt she had to smoke to calm her anxiety before leaving the house. In this situation, she needs a job to survive, and smoking helps her achieve that goal.

Oftentimes, clinicians view survival techniques as immediate yet short-term actions or behaviors, particularly in the presence of a threat. However, due to the ever-present exposure to community violence, these survival techniques became a part of these participants day to day life. Essentially, the threat is always present. Therefore, the survival techniques transform into adapted behaviors.

Sometimes Resilience is Adapting

Clinicians and youth described an overlap between behaviors that began as short-term responses to trauma that then transitioned into adapted behaviors that became part of youths' daily activities. Because youth participants' exposure to community violence was chronic, adapting is more of a long-term adjustment to community violence. Throughout this section, you will read excerpts from patients and clinicians as they all attempt to define and explain adapting to community violence.

As expressed in the previous section, many of the survival techniques youth had to employ to survive immediately were best suited as temporary responses to trauma or a threat. However, clinicians realized through their exposure to community violence trauma recovery that the environment greatly shifts how they respond to patients' utilization of survival techniques and responses to trauma. One clinician expresses that the challenge with trauma recovery is that the environment does not change, so the mechanisms that clinicians would want youth only to use temporarily have a long-term function. She expresses:

> This is what makes trauma recovery so challenging, especially if your environment never changes…You have me, as your therapist, talking to you about hypervigilance and the stress and strain it puts on your body. But it is also adaptive because when the world you live in on a day-to-day basis is potentially threatening all the time, you're ready to protect yourself. That's adapting." – Dr. Briana

Getting Used to it

Youth participants often expressed that their actions and behaviors are deeply shaped by their consistent exposure to trauma and how it can be challenging to shift their mindset and behaviors while they are still living in a community with elevated rates of violence. A youth participant, Kyla, lived in a community plagued by violence her entire life. She discussed how, as far as she can remember, she was taught different mechanisms and given advice on how to navigate community violence. When she was asked about how she was adapting, she stated:

> I wouldn't really say adapting with it. It's more like, well, I guess because I'm getting used to it because I've been living over here for so long…I don't really think anybody would be adapted… Like there's no more really adapting that I can do at least living over here." - Kyla 15 y/o female

Kyla's sentiment about struggling to adapt aligns with Dr. Briana's acknowledgment of the challenge of attempting to adapt while still living in a neighborhood with chronic community violence exposure. As Kyla describes her understanding of adapting, she equates it with "getting used to it." From the discussions with youth participants, adapting is synonymous with adjusting and getting used to living in communities with violence exposure. She followed later in the interview by saying, "I wouldn't say I'm adapted to it. I don't really think anybody would be adapted."– Kyla 15 y/o female

One significant difference that emerges in the patient interviews regarding adapting is how they operationalize community violence exposure. For some patients, they are adapting to

life after being physically harmed by community violence, such as being shot or stabbed. Members of that group often described adapting physically and psychologically. Others described how to adapt to witnessing community violence.

Jaylen, who was physically injured, uses the term adjustment as he describes his experiences with community violence. He describes life after being shot as a "big adjustment" because he could not participate in activities like he did before the shooting. Jaylen states:

> At the time. I was just a completely different person. I was learning my whole life over, like a person has always gone outside doing stuff and being forced to sit in the house. This is a big adjustment. - Jaylen 20 y/o Male

Trey was also physically injured and expressed how his understanding of adapting was related to adapting to his new physical and mental state. He describes:

> I remember when I came home, I fell out of the wheelchair because I tried to stand up three times. I failed the last time. I couldn't walk or couldn't stand up for another 30 days… I'm still not all the way there. The strokes really affected my decisions and my mindset. I wouldn't want my kids to go through that if I ever have any. - Trey 20 y/o male

Participants describe how they are adapting or getting used to their environments or circumstances, but what does it mean to adapt well?

Adapting Well for Me

One of the guiding research questions for this study examines what it means to adapt well to community violence. For clinicians, adapting well and demonstrating resilience meant being involved, engaged, and interacting with life despite the things happening around you. A clinician expressed he saw a difference between adapting and adapting well. When describing what it means to adapt well, he states:

> Acknowledging that this is the reality of your environment and of your community, and actively being involved in activities or things that try to balance out this harmful reality. – Dr. Mario

For clinicians, the discussion of adapting and adapting well brought up ideas of surviving and thriving. When asked what adapting well looks like in the presence of community violence exposure, Nicole, a former clinician, stated, "We say adapting, I think maybe we are thinking thriving." Another clinician stated, "Joy is what takes it from surviving to thriving"- Dr. Brianna

However, youth participants had different versions and perspectives on adapting well. Cameron expressed that he is adapting well because he is eating more and becoming more active.

> Well, I eat better than I used to, for sure that. I like to exercise. Like to just get up and, you know, because I don't want to be sitting on it just be sitting around and not you know, working out on my body. It still needs more healing, but I have to stay active. – Cameron 19 y/o male

Throughout his interview, Cameron discussed the mental and physical impact of community violence. Because of his direct exposure to gun violence, Cameron was adapting physically and mentally.

Jaylen describes adapting well as the ability to do things he did before his direct exposure to gun violence. Jaylen states his understanding of adapting well is "Being comfortable with any activity, being able to go outside as freely as I used to." Throughout this interview, he thought a lot about the similarities between adapting well and demonstrating resilience. When asked how he felt he was adapting, he said, "I feel like I'm getting there. I am probably about 70%- 80% to where I want to be with my comfortability." Since Jaylen said he was about 70-80% of where he wanted to be, I then asked him to discuss his life at 100%. How would this look in his version of adapting well?

He expressed, "I would say, without me smoking, like me finding a way of being happy

outside of that. That is a full adaption for me." Throughout Jaylen's interview, he described his history and relationship with smoking marijuana. Before his exposure to gun violence, he smoked recreationally. Then, it began to help with the pain of his gunshot wound. He also said smoking became the only way he could leave the house due to his anxiety. Finally, he expressed that smoking just became a habit, and he always found a reason to smoke. Therefore, to reach the level of adapting that he desires, he described that changing his relationship with smoking marijuana was essential.

Further in the interview, we discussed what it means to not adapt well to community violence, and Jaylen gave an example of someone who attended physical therapy with him. As he described this story, he mentioned that this person was consistently attending physical therapy because he had been shot on separate occasions. The person was gang-affiliated, and he mentioned that he was looking for revenge and vengeance. Jaylen categorized this person and this type of behavior as an example of not adapting well and not being resilient. He states:

> I felt as though he wasn't resilient. Because he just wasn't looking at the bigger picture. Like, he can look in the moment of, "Man, somebody did this to me; I can't let that slide." Going for revenge and vengeance is easy. The hard part is taking the acceptance of life for what it is and making the best of it. – Jaylen 20 y/o male

Cameron expressed a similar sentiment on changing behavior after exposure to violence. He mentioned how, after his accident, he stopped doing certain behaviors because "it was not worth it."

Up to this point, we have explored the perspectives of both patients and clinicians regarding resilience in the context of exposure to community violence. Through these discussions, it became evident that resilience encapsulates survival strategies, adapted behaviors, and coping mechanisms. However, both clinicians and patients encountered difficulties with the

term "resilience." They grappled with the notion that individuals shouldn't have to exhibit resilience and the common public perception that resilience implies being unaffected or effortlessly bouncing back from trauma or adversity. However, a new theme emerged in the patient focus group that added an additional layer of nuance to the concept of resilience in the presence of community violence exposure.

Resilience is a Rewarded Character Trait that Comes at A Personal High Cost

Throughout semi-structured interviews, collectively, youth and clinicians often regarded resilience as a negative concept. Youths' display of resiliency was expressed more as something that they had to do instead of wanting to do. They had to be strong and recover fast, and in their interviews, we discussed how detrimental that can be. However, in the focus groups, I recognized a distinct shift in the approach. In the focus groups, youth participants discussed the importance of seeming resilient and why this characteristic is essential to survival.

All the focus group participants agreed that being resilient is accompanied by costs, including people not liking you for changing your behavior and actions. Mya, who entered the clinic due to a violent incident with her sibling, expressed that one of the most dangerous components of being resilient is holding all your emotions in.

Jaylen added that an additional danger with people perceiving that you are resilient is that it can be uncomfortable for people to see you down or not in the best mood:

> The problem with this is when people see you as an uppity person with positive energy, and they finally see you down, it can come off weird to them because they see you as being a positive person who does not let things get them down. – Jaylen 20 y/o male

The conversation began by discussing resilience, people's expectations that you always be okay, and the challenges of not meeting other people's expectations. However, Mya and Trey

evaluated this concept in the inverse. They described the hardship of people expecting you to be down and not wanting you to get up or be okay in the presence of adversity:

> It is not common that people want you to win. Many people want you to stay down with them and don't want you to change your behaviors. Even your own family. – Trey 20 y/o male

As we moved through the conversation, we worked together to discuss how the challenges of resilience change based on who views you as resilient. All participants agreed that if people in the REACT clinic or in other supportive roles perceive them as resilient, they will assume they don't need help, or the assumption is that they will always be okay. However, in the neighborhood, peer groups, and even in some family dynamics, participants agreed that resilience is a critical attribute to surviving, especially when the expectation is for you to succumb to your circumstances and life experiences.

In this chapter, I show how Black youth exposed to chronic community violence and their clinicians understand the concept of resilience. This exploration is based on the viewpoints and experiences of clinicians employed in a community violence clinic and adolescents residing in neighborhoods characterized by elevated levels of community violence exposure. The foundation of this chapter is based on resilience and supported by the concepts of adapting and surviving through the lens of patients and clinicians.

Discussion

I found that clinicians' recognition of resilience as appearing differently than described in traditional contexts aligns with much of the existing literature on community violence exposure and resiliency (Woods-Jaeger et al., 2020). However, one great contribution of this chapter is clinicians' ability to recognize how their training in the REACT clinic altered their perspective

on certain concepts, such as resilience. Before their training, clinicians often viewed resiliency as adapting to adversity or bouncing back from hardship by using adaptive behaviors, but through their training, they recognized that this definition of resiliency is not applicable to many individuals exposed to community violence, but it also does not mean these individuals should not be classified as resilient. Clinicians discussed how they may not use the word resilient to describe their patients because, from many of their interviews, they believe no one should have to be resilient, meaning people should not have to continuously be exposed to adversity and be expected to always recover, especially without the proper resources. Nonetheless, although clinicians disliked the application of the term, many clinicians identified that many of their patients exemplify the pillars of what it means to be resilient. For some clinicians, that simply meant surviving, but for the majority, resilience is similar to thriving or aiming toward thriving. From clinician interviews, resiliency in their patients looks like being active, engaged, and having hope.

Patients had similar descriptions of resiliency, but they spent a lot of time describing the choices and behaviors involved within resilience, more specifically, the actions not aligned with resilience. Patients expressed how wanting to be resilient required a certain mindset and ability to avoid harmful situations. In instances where patients described staying in the house or limiting interactions with peers, these behaviors can be perceived as detrimental to their social development, but patients' lack of access to resources required them to withdraw often for safety reasons.

Clinicians and youth described resilience as an overarching concept, with survival techniques and adapted behaviors being essential actions involved within resilience. I used participants’ responses to redefine and describe these concepts within the realm of community

violence exposure. For survival techniques, patients and clinicians both described actions or behaviors that are employed in the presence of a threat. However, clinicians and patients described different time periods for using survival techniques. For clinicians, survival techniques were seen as temporary and immediate responses to threats, but for patients, that description was too limiting. Patients in this study described using a plethora of survival techniques on a daily, even without the presence of a threat. For clinicians, certain behaviors should be turned on and off. However, for patients, threats are ever-present, and the survival techniques that they have inherited from family members or friends or learned from their own circumstances have kept them safe to the point where it is a part of their routine.

Youth initially coped by utilizing survival techniques, but these techniques transitioned into adapted behaviors over time. Techniques that were seen to only exist in a short window of time can potentially be a part of someone's entire life. Acknowledging how survival techniques can develop into adapted behaviors speaks to the permanence and serious nature of community violence exposure. When clinicians think of survival techniques, they also have to consider that their patients may spend every day in an environment that requires them to be in the presence of constant direct threats, so the survival techniques that they employ are no longer temporary but a part of their daily lives.

When youth describe what it is like to adapt to community violence exposure, for some, there is no such thing as being able to adapt to this type of environment. It is a constant battle of learning and relearning behaviors and actions that prioritize their well-being and safety. This notion of never becoming fully adapted or adjusted to community violence exposure emphasizes why so many clinicians dislike the concept of resilience. Clinicians in this study support their patient's ability to adapt and recover, but they also recognize that no one should have to

continuously adapt and recover, and they also understand how challenging it is to have to try to recover in environments that hurt you.

Part of the formal definition of resilience involves the ability to adapt well, and one great contribution of this chapter is having the youth's voice describe what adapting well means to them. For many youth in this study, their experience with adapting had a physical component. For patients exposed to direct forms of violence, adapting also meant getting used to your new body and potential physical limitations. Three males throughout this study described their physical journey with adapting to their body after being shot multiple times in addition to the mental adjustment they had to do by recognizing their new physical limitations. The physical adaption was easier to measure because participants simply compared their abilities to what they were before their traumatic incidents. However, their responses were more nuanced when discussing overall what it means to adapt well. Overall, patients had varying responses on what it meant to adapt well, but many patients discussed how eliminating their dependence on marijuana would aid in their ability to adapt well.

Clinicians and patients had similar understandings of resilience. However, there were stark differences in how patients described their understanding of resilience in the individual interviews compared to the focus group. In the individual interviews, many patients discussed the harms of resilience or the idea of being expected to continuously adapt and recover from adversity. This notion aligns with why clinicians had such a disdain for the concept. For patients in this study, they described how if people in support roles, such as therapists, view you as resilient, they may think you are okay and do not need help or additional support. However, this dislike for resilience shifted in the focus group when participants started describing the importance of resilience and how, in many ways, the attributes associated with resiliency are

survival techniques. Many participants described how important it is for people to see themselves as resilient in their peer groups, schools, and communities. In many ways, being resilient means you are not vulnerable, so you are less likely to be targeted if people assume you will not be greatly impacted by negative actions. Therefore, a part of patients' adaptation to community violence is consistently participating in the performance of being seen as resilient by appearing strong and hiding emotions to protect themselves. This practice, however, becomes detrimental in spaces like therapy because then it becomes hard for patients to share their feelings and express vulnerability because these are behaviors that can cause them harm in their communities.

Conclusion

The implications of this chapter demonstrate how researchers and trauma recovery specialists need to expand their definitions and understanding of resilience for youth growing up in environments with chronic adversity. For some youth in this study and other youth experiencing chronic adversity, their ability to survive is being equated as resilience. While survival mechanisms are a component of resilience in these contexts, resilience is not simply surviving. By labeling survival resilience, we are essentially disregarding the harmful effects associated with the consistent use of survival mechanisms. For other youth, their ability to demonstrate resilience and make meaning of their circumstances is undervalued due to their lack of access to resources. Future research should explore their creativity and resourcefulness as strengths to find additional ways to foster resilience and promote recovery in these environments.

CHAPTER TWO: BALANCING ACTS: NAVIGATING COMMUNITY VIOLENCE THROUGH ADAPTIVE AND MALADAPTIVE COPING STRATEGIES

Coping strategies play a crucial role in health research as they have immediate and long-term effects on both physical and mental well-being. Utilizing coping mechanisms and protective factors is vital for fostering resilience by mitigating risks and facilitating successful adaptation. (Boxer & Sloan-Power, 2013; Tugade & Fredrickson, 2004). Coping refers to the process of managing or dealing with stress, adversity, challenges, or difficult emotions. This process employs various conscious and voluntary behaviors, thoughts, and emotions to adapt to difficult circumstances or to alleviate distress. Coping mechanisms can be both healthy and unhealthy, depending on how effectively they help individuals navigate and manage their stressors (Algoroni & Gupta, 2023). Coping is similar to defense mechanisms, primarily because defense mechanisms are unconscious responses, whereas coping mechanisms are conscious responses to stress (Algoroni & Gupta, 2023).

Research suggests that youth who are exposed to community violence begin developing coping mechanisms at early ages (, 2008). By mid to late adolescence, youth typically have developed a range of strategies to cope with stressful environments (Wadsworth, 2015). Some of those strategies include approach-focused coping, such as problem-solving, or avoidant-based coping, such as repressing or blocking out the problem (Edlynn et al., 2008). The literature is mixed on the effectiveness and function of these strategies, but findings indicate that these coping strategies are often employed to help youth stay safe (Teitelman et al., 2010). The study of coping is additionally important because, depending on the effectiveness of the coping mechanism, it can provide additional protection or increase vulnerability (Edlynn et al., 2008).

Exploring how context impacts coping makes the relationship between coping and community violence important due to the stressful, uncontrollable, and traumatic nature of this context. Furthermore, coping strategies have the potential to aid in individuals' ability to manage adversity and build resilience, which is essential for navigating the challenges of living in communities affected by violence. This review focuses on the broader categories of adaptive and maladaptive coping, but there are many labels and categories to classify coping, and they are context-dependent, meaning that certain strategies are more fitting and applicable based on that context. A 2022 study on community violence and coping utilized the cognitive-transactional model to explore how the effectiveness of a coping strategy depends on the situation and controllability to inform the best coping strategies for youth exposed to gun violence (Folkman et al., 1986; DiClemente & Richards, 2022). Under this model, the effectiveness of the coping strategy is contingent on the controllability of the stressor (Edylnn et al., 2008). This evidence is important to this review because while this research is based on the context of community violence, there is still a lot of variability within people's experiences of community violence exposure, which in turn creates a range of responses to different forms of exposure.

Adaptive Coping

Adaptive coping strategies are typically regarded as positive behaviors and tools that individuals use to manage stress that brings a more positive outcome or does not further add harm (Javeed and Parveen, 2021; Cortez et al.,2023). Adaptive coping serves as a protective factor to potentially decrease the adverse effects of exposure to adversity or trauma (Holahan et al., 2017). Examples of adaptive coping may include problem-focused strategies and activities that help with distress, such as exercise, listening to music, and religion/spirituality (Holohan et

al., 2017; Kirmayer et al., 2012). Other research has also supported music as a popular coping mechanism among youth. A mixed-methods study on coping and violence found that over 90% of youth endorsed listening to music as their primary coping mechanism (Flannery et al., 2004). Additionally, emotional regulation has been well-documented as an adaptive coping mechanism (Heleniak et al., 2016).

Research has shown that adaptive emotional regulation can serve as a protective factor for children against externalizing and internalizing symptoms (Daniel et al., 2020; La Barrie et al. 2022). The relationship between emotional regulation and community violence exposure is of particular interest because previous research notes that community violence exposure may disrupt emotional regulation, which then puts youth at a heightened risk for internalizing psychopathology (Heleniak et al., 2016).

In analyzing the association between community violence and coping, researchers found that adaptive coping behaviors were not associated with violent behavior for youth who coped well. A 2007 study analyzing the relationship between community violence and coping found that youth who employed adaptive coping behaviors utilized mechanisms such as seeking advice, focusing on positive aspects of their lives, playing sports, and arranging to live outside of their neighborhood (Brady et al., 2008). In contrast, youth who utilized maladaptive coping or ineffective coping had an association with greater violent behavior during late adolescence (Brady et al., 2008).

Maladaptive Coping

Maladaptive coping strategies are behaviors that may temporarily reduce stress or the impact of the stressor but are greatly associated with poor health outcomes and problematic behavior (Algaroni & Gupta, 2023; Metzger et al., 2017). Maladaptive coping often stems from adverse childhood experiences. Children who are exposed to chronic and persistent stressors such as poverty are less likely to engage in problem—solving and emotion-management/regulation coping behaviors (Wadsworth, 2015). Avoidant coping is the opposite of problem-solving coping and is often categorized as maladaptive coping because this form of coping does not focus on the stressor or the problem (Herman-Stahl et al., 1995; So et al., 2021). A reliance on avoidant coping is associated with depressive symptoms, which may also create a route to other chronic stressors (Holohan et al., 2005).

Youth exposed to higher levels of violence are more likely to engage in using maladaptive coping mechanisms (Flannery et al., 1998; Flannery et al., 2004). There is an established relationship between maladaptive coping mechanisms and disorders such as anxiety, PTSD, and depression. Common maladaptive coping mechanisms in trauma victims may include avoidance, self-blame, and substance use (Choi et al., 2015; Edlynn et al., 2008). Individuals who experience greater life stress are more likely to use smoking and cannabis use for coping (Hyman & Sinha, 2009).

In an analysis of community violence and coping, researchers found that the maladaptive mechanisms youth used were engaging in substance use, fighting, self-isolation, and holding in their emotions (Brady et al., 2008). Research suggests that youth who over-rely on maladaptive coping mechanisms are more likely to have behavioral and mental health problems (Flannery et al., 2004).

Interplay of Adaptive and Maladaptive Coping

Research on child development and stress suggests that exposure to chronic stress encourages children to utilize both maladaptive and adaptive coping simultaneously (Wadsworth, 2015). In reference to community violence exposure, the literature has mixed reviews on how these behaviors are classified (So et al., 2021). Furthermore, the literature provides evidence that suggests behaviors typically classified as maladaptive have adaptive properties depending on context. For instance, confrontation was a mentioned coping mechanism for boys exposed to community violence. However, this mechanism has not been well-documented as a coping mechanism in previous literature (Voisin, 2011). Additionally, that research also concluded that girls in Chicago would employ avoidant coping strategies, and those mechanisms were to protect them from harm (Voisin, 2011). A similar study found that youth utilized avoidant behaviors in the context of community violence because focusing on this level of uncontrollable stress may lead to more worry and distress (Edlynn et al., 2008). Outside of the literature on community violence exposure, avoidance is typically categorized as a maladaptive or negative coping mechanism because it is associated with emotional symptoms or behavioral problems (Choi et al., 2015; Voisin, 2011; So et al., 2021; Boxer & Sloan-Power, 2013). Additional research has shown that in the context of community violence, avoidant coping has been linked with lowering anxiety and associated with providing a sense of protection for youth (Edlynn et al., 2008).

In the inverse, research suggests that some coping behaviors categorized as adaptive may have negative and long-term consequences (Voisin, 2011). For example, problem-solving behaviors are typically categorized as adaptive. However, research suggests that boys exposed to community violence who tried problem-solving behaviors may be at more risk. Attempting to

solve the problem could be associated with more aggressive behaviors (DiClemente & Richards, 2022). Furthermore, youth attempting to use problem-solving for a problem that is outside of their ability to solve may present unintended consequences or harm (Boxer & Sloan-Power, 2013).

According to the adaptive calibration model, when someone is exposed to a chronically stressful environment, vigilant and avoidant behaviors are biological stress responses and adaptive coping behaviors (Wadsworth, 2015). While these behaviors are associated with physical and mental health problems, they can also be protective. This analysis reframes maladaptive coping as functional adaptation (Wadsworth, 2015). Further research supports this finding by demonstrating that negative emotions such as worry, sadness, and anger can be functionally adaptive and help youth respond to environmental cues (La Barrie, 2022). In reference to community violence exposure, there are mixed findings on the classification of coping mechanisms. Literature has shown that there are a lot of nuances in these mechanisms, and they constantly change to adjust to the controllability of the stressor (So et al., 2021; DiClemente & Richards, 2022). The analysis of coping within the context of community violence highlights the complexities and nuances of these mechanisms (DiClemente & Richards, 2022).

While emerging literature recognizes the complexities of coping with community violence, there are still gaps in understanding the function of these mechanisms. Furthermore, many studies are analyzing pre-established coping mechanisms such as avoidance and self-isolation. However, there are more unidentified or underrecognized mechanisms that youth may employ. In this chapter, I examine how clinicians and youth discuss a range of coping mechanisms and the functions, benefits, and harms of each mechanism.

Methods

Participants for this study were recruited from the REACT program and clinic, a community violence trauma recovery program. A part of this program is the REACT clinic, which is an interdisciplinary clinic that provides trauma-focused interventions and psychological and psychiatric support to families impacted by community violence.

Six clinicians and nine youth participants were recruited from the REACT Clinic. Five of the clinicians were female, and one was male. Six of the youth participants were male, and three were female, ages 15 to 20. All three of the female participants had witnessed community violence and experienced indirect physical harm. All six of the male participants had witnessed community violence and experienced direct physical harm. More details about the participants can be found in the introduction chapter.

The data analyzed for this chapter explores clinicians' and youth participants' responses to open-ended questions related to coping mechanisms and protective factors through semi-structured interviews and a focus group. These questions aimed to explore the mechanisms youth utilize to cope with exposure to community violence.

The introduction chapter provides the full methods and analysis for this study. The first phase of data collection was semi-structured interviews. Before each interview, participants and/or their parent/guardian (for participants under 18) were given a consent/assent form to sign. Participants were also informed that the interviews were audio-recorded, and their confidentiality was protected.

This section of the youth interview asked them questions about the behaviors and actions they partake in to cope with their exposure to community violence. The specific questions were:

1) How would you say you are coping with the experiences you have described?
2) Would you describe these behaviors as positive or negative/ healthy or unhealthy?
3) How effective or helpful are these coping behaviors?
    a. What coping mechanisms do you observe your friends or other youth using to cope with community violence exposure?

This section of the clinician interview asked them to provide their psychological understanding of coping behaviors, particularly in the context of community violence and the maladaptive and adaptive function of these behaviors. The specific questions were:

1) How do you define coping?
2) How do you define adaptive coping?
    a. Can you provide examples of adaptive coping?
3) How do you define maladaptive coping?
    a. Can you provide examples of maladaptive coping?
4) What are the typical ways you see youth coping with community violence exposure?
5) Based on the mechanisms you described youth using, would you classify these behaviors as maladaptive or adaptive?
6) What do you believe youth need more of to help them cope better?

The second phase of data collection was youth focus groups. In this part of the study, youth participants collectively shared their coping mechanisms with other study participants from the REACT clinic. They discussed common coping mechanisms they observed other youth using.

Coding and Analysis

This analysis incorporated both inductive and deductive coding. Starting with deductive coding, the data was sorted into broad topical categories based on the concepts within the research questions and the interview protocol. Primarily focusing on concepts such as resilience, coping, adapting, and surviving.

Later in the coding cycle, two evaluators conducted inductive coding to develop themes and findings and identify patterns across the interviews and the focus group. A codebook was generated to highlight the most prevalent themes from the interviews and the focus group. All

members of the research team reviewed and provided feedback to finalize the codebook. The prevalence of each theme and subtheme was assessed across interviews. Selected subthemes from this chapter are illustrated in Table 2.

Table 4: Subthemes and Example Quotes on Coping Strategies

Subtheme	Example Quotes
Defining Coping In The Context Of Community Violence Exposure	"Coping is things I'm doing to keep me moving forward. Survival things is in order for me to stay alive today. I need to think through how to get around these potential problems is coping. It's like, I need to use this so that I can keep going forward."- Dr. Amanda "I think a coping mechanism is something that you ideally practice even without the presence of stressors at the same time. So like, something that you can practice and get better at." – Dr. Mario
Coping Mechanisms	"I had a very large caseload of just boys who didn't want to talk. I would say for them, it was a lot of like, I'm gonna get high or sometimes it would be I'm gonna go play basketball, or football and like, that's where I get to have my emotional release. I had a few youth participants that were into rapping. So making music of some kind, a lot of it was getting high, though, spent a lot of time talking about getting high." - Dr. Amanda "Well, I just talk to people. People my age who have been through the same thing. I feel like it's better to talk to somebody who's been through it, or also going through it because they understand where you're coming from. So then not just like, notice things that were pulling back in that same situation as the one I just moved on from." - Dana
Dual Function of Maladaptive and Adaptive Coping Mechanisms	"Staying at home from school, like avoiding school can be maladaptive, I think, but it could also be adaptive in some ways"- Dr. Kara "I always have struggled to sort of think through what's adaptive and maladaptive for families, and kids. Because even like substance use, for example, is a very like, has historically been a very racialized experience. Until now, all of a sudden, everyone is allowed to smoke weed. And now it's like, yeah, so just a, it's like mindfulness. Right? But then like back in the 90s, and the 80s. People were being locked up for it. So I think what's adaptive or maladaptive adaptive changes in context. But to answer your question, I think that all of them can be adaptive to some degree." – Dr. Nicole
Gang Involvement as A Protective Factor and Coping Mechanism	"Joining street gangs and stuff like that, that's an adaptation to a tee. That is protection. That is honestly wise in some spaces, in some environments, it is wise to be connected to a group of people who you know, are going to be looking out for you who you know, other folks in your community know of and know not to mess with you. That's why people do it. That's why kids do that."- Dr. Brianna "Even having a strong connection to, or strong participation in gang-related social groups can be adaptive"- Dr. Nicole

Avoidance As Protection	"Thinking about avoidance, like a lot of the kiddos like, don't want to go outside and play with their friends anymore, or may sort of be nervous to walk to school or may avoid school entirely, because, the trauma that they're experiencing may have been done by somebody at school, or once they left school, or may have happened by somebody in the community on their way to school. So, kind of avoidance in that way". - Dr. Kara "I don't like to get into arguments, so I try to avoid conflict and try to get a reasoning between me and the next person."- Trey
Drug Use As Avoidance	I think there's a lot of avoidance, I think there's a lot of like, I don't want to feel my feelings, I want to numb myself, which was a lot of like the drug use that I saw. So, lots of kids would get high as a way to not feel. - Dr. Amanda Marijuana use is a common one. Other people just describe feeling numb, you know, and kind of just trying to passively block those thoughts or those feelings and kind of going about their day and trying to kind of become numb to these reactions. – Dr. Mario

Results

Clinicians reported that many of the mechanisms that youth used to cope with their exposure to community violence were similar to their survival techniques. Some clinicians struggled to distinguish between the two concepts:

> Coping is like things [the youth are] doing to keep moving forward. The survival thing is like, in order for [them] to stay alive today. I need to think through how to cope with these potential problems. It's like, I need to use this so that I can keep going forward. I have to think more about the differences between those two concepts. – Dr. Nicole

Clinicians reported that youth employed a lot of variation in coping mechanisms. While all the youth participants have exposure to community violence, their coping behaviors vary based on resources and protective factors, such as strong family dynamics. Youth with parental involvement were often involved in extracurricular or sports activities and were less likely to engage in potentially harmful behaviors such as substance use.

Coping is broadly defined in the literature as thoughts and behaviors used to manage a

stressful situation, typically divided into maladaptive and adaptive behavior. Literature on coping mechanisms typically creates a stark divide between the two categories. However, through these interviews, I found that there were some subtle distinctions, but not stark differences, in how coping mechanisms are categorized in the presence of community violence.

Music is a Universally Adaptive Coping Mechanism

In some instances, the classification and function of a coping mechanism is clear. The most commonly reported coping mechanism was music. Most youth participants reported already using music as a coping mechanism before receiving any therapy or psychological support. One participant, Trey, described in the focus group how, after his shooting, he started writing raps to describe his experiences.

Clinicians also reported that music was a common mechanism they would recommend because it was well-received by patients. One clinician stated that music was the most utilized mechanism she sees in her patients:

> Music every time. Every time music, whether it be a kid has been expressing themselves through music, or identifying their traumatic experience or identifying the feelings that are like floating through them that they don't have the words for. Black kids are amazing with what they do with music and how healing it can be. Using music to express themselves, music to calm themselves, that's the most consistent thing I would say working with black children who've been traumatized. I always see them naturally gravitating towards music for healing. -Dr. Brianna

While music is a highly studied and evidence-based coping mechanism, for many of the patients in this study, music, especially in the genres of hip-hop and rap, made it extra sentimental. Many of the youth participants who mentioned music as their coping mechanism noted that hip-hop and rap music, specifically from Chicago, is what they often relied on. Chicago is a major hub and producer of popular rap music. However, for the youth participants in this study who all

reside in Chicago, it makes utilizing music as a coping mechanism even more valuable because of its location and proximity to their birthplace. Dr. Brianna expresses it through the following:

> Chicago is Black music. A lot of the music that resonates with kids here comes right from the block that they're from. A lot of the time they know artists personally. I had a kid who we were talking about music and what brings her comfort. She's very, very anxious. A part of her trauma is anxiety, fearfulness, and being on edge all the time. Something that brings her a sense of calm is a song by G-herbo. In this song, he shouts out her uncle who was killed when she was a kid and this was an uncle she saw as a protector, who lived and died in the place she calls home...A lot of times for kids in Chicago, it really hits them in a different way, because they are so familiar with the experiences behind the sound. Then sometimes it's familiar with the people behind the sound as well, so much so that she hears her uncle's name every time she turns that song on to calm herself, she also hears this person that she has lost but loves and adores and uses as a place of comfort and safety. -Dr. Brianna

Challenges Distinguishing Adaptive and Maladaptive Coping

This interview section also presented challenges for clinicians, as they were asked how they would define, apply, and classify coping mechanisms. Clinicians struggled to classify the function of coping mechanisms based on their formal training in comparison to how they perceive coping mechanisms employed within community violence and through their work at the REACT clinic.

For example, clinicians were asked to give examples of maladaptive and adaptive coping mechanisms that their patients may use. Dr. Nicole, described her struggle with differentiating between maladaptive and adaptive because the classification varies based on demographic:

> I've been trained to consider adaptive as what's normal and what's normal is as close as you can get to whiteness. I always have struggled to sort of think through what's adaptive and maladaptive for families, and kids. Because even substance use, for example, has historically been a very racialized experience. Until now, all of a sudden, everyone is allowed to smoke weed. Now it's like mindfulness, but back in the 90s and the 80s, people were being locked up for it. So, I think what's adaptive or maladaptive changes in context. - Dr. Nicole

Dr. Mario describes maladaptive coping as behaviors that will lead to more harm than good in the long run. However, he also recognized these same behaviors could be adaptive depending on how they are used:

> I think youth who employ any sort of coping strategy, a survival technique, or a maladaptive coping mechanism are doing it for a purpose. I think that the purpose is for them to feel safe or distracted. Within the context of community violence, I think the maladaptive piece, the way I think about it, is something that, in the long run, will be causing more harm than good. So with substance use, again, I think you'd have to look at the literature. That's the way I think about it in terms of what's been documented as helpful and or harmful. With substance use, if you have a kid who is smoking marijuana or drinking a significant amount, or more than they should, this has negative impacts on brain development. I would consider that maladaptive because in the long run, even though it's temporarily helping them feel safe or distracted or out of distress, in the long run, it may have a negative impact on their functioning as an adult, as a student, socially, or with the juvenile justice system if they get involved with that. I think substance use would maybe fall into that category, but again, depending on how much because research has shown that some substances do help with depression and anxiety, and a lot of those symptoms are related to trauma too. So, I think they could be helpful and monitored and work within a professional type of setting. I think there's just a lot of nuances to it. - Dr. Mario

While clinicians seemingly agree on the definition of a maladaptive coping mechanism, identifying specific mechanisms that are maladaptive had more variability. Dr. Nicole discussed that people cope with community violence by connecting with other people with similar experiences, including joining gangs:

> I do think that one way that people cope with the effects of violence are connecting with people who've had the same experience. Then we wonder why gang relations are so close-knit and that they will literally die for each other. I think that, in some ways, that can be a coping mechanism or a sense of belonging with people who have shared experiences. – Dr. Nicole

Adaptive and Maladaptive Aspects of Gang Involvement

Most clinicians mentioned gang involvement as a common coping mechanism, but opinions varied on whether this is an adaptive or maladaptive mechanism. Dr. Nia mentioned

substance abuse and gang involvement as maladaptive mechanisms, but she also described why patients may join gangs similarly to Dr. Nicole's explanation:

> The potential to sort of become involved with gangs or those kinds of things to develop a sense of safety or feel like you're safe or feel like you have somebody protecting you or watching your back kind of thing. Acquiring weapons, I think, could also be to try to feel safe. – Dr. Nia

Dr. Nia's explanation of gang involvement highlights how some coping mechanisms may be seen as maladaptive but have some adaptive components, especially when they are used to provide a sense of safety or protection. Similarly, Dr. Brianna also classified gang involvement as adaptive and resilient:

> It's important to me to acknowledge how adaptive and resilient gang life is. I think that it's something that should be valued and elevated. - Dr. Brianna

Avoiding and Isolating

Youth participants were also asked to describe and categorize their coping mechanisms by behaviors they perceive to be helpful or harmful. Many youth participants stated that avoiding and isolating were helpful behaviors to cope with community violence. In her interviews, Mya stated she isolates herself by putting in her headphones and listening to music to avoid overstimulation, especially in large group settings such as at the grocery store. As previously explained, she expressed how music is a coping mechanism that has helped her with her social anxiety.

Other participants reported avoidant coping as a primary coping style to avoid certain places and people. Due to this high level of avoidance, many youth found themselves often isolated at home.

One participant stated he and his sibling stayed home a lot after their violent attack; he states:

> [Staying home] is more positive. Just not getting involved in BS and being in the wrong place. I just really talk to my family; we have game nights and watch movies". - Justin 15 y/o male

While this youth and his sibling are seemingly isolating and avoiding going outside after their traumatic encounter, he provides further context to how he spends his time at home. Other youth expressed activities they do at home to stay productive, such as working out, creating business plans, and spending time with family.

Clinicians also mentioned how avoiding was a common behavior they witnessed in their patients. Dr. Kara expressed how she often sees youth avoiding being outside, hanging with friends, or going to school because of their exposure to community violence:

> Thinking about avoidance, a lot of the kiddos don't want to go outside and play with their friends anymore or may sort of be nervous to walk to school or may avoid school entirely because the trauma that they're experiencing may have been done by somebody at school, or once they left school, or may have happened by somebody in the community on their way to school. So, kind of avoidance in that way. - Dr. Kara

Another clinician also expressed avoidance as a common coping mechanism but also reported this form of coping as a problem-focused form of coping:

> I think [avoidance is] problem-solving. If you actively are trying to avoid a specific part of town during a specific part of the day, they really can problem solve, like how to get around exposures to more violence. They're able to problem solve their ways out of, police encounters, problem solve their way out of like housing problems. - Dr. Amanda

Avoidance is often regarded as a maladaptive coping mechanism, but through these excerpts, youth and clinicians described the adaptive function of coping, particularly to maintain safety and solve their problem of exposure to violence.

The Short-Term Adaptive Role of Self-Medicating

Marijuana use was a very commonly reported coping mechanism within this study. Many youths described self-medicating by using marijuana to help them cope and function. In some instances, youth use marijuana to replace other prescribed medicines to help with symptoms such as nausea caused by a side effect of another prescribed medication. Generally, most clinicians reported drug or substance use as a maladaptive coping mechanism. Patients also viewed substance use as a potentially harmful behavior. The majority of youth participants in this study stated that their use of marijuana is a coping mechanism. For many, smoking marijuana began as a casual or recreational activity but then became a habit they were reliant on and something they felt they needed to cope with exposure to community violence. As described earlier, Mya uses her headphones to listen to music in largely populated spaces. However, she works at a warehouse and can't use her headphones at work to help her with her anxiety which developed after her brother was shot. Therefore, she smokes before working to help ease her anxiety:

> When I'm at work, I have my anxiety that there's too many people where I work. So if I don't smoke, I'm going to be in my thoughts too much. - Mya 20 y/o female

Trey also stated that listening to music and smoking marijuana were his primary coping mechanisms. He described smoking as something that he does to cope but also to help with physical pain. He states:

> Marijuana helps me physically, mentally, and emotionally. Marijuana is positive but my actions after are not. – Trey 20 y/o male

In the focus group, youth participants collectively expressed that smoking marijuana was essential for coping but also recognized that smoking comes with various costs. Jaylen expressed:

> I know one thing that I need to quit, that I've been using to cope is smoking marijuana daily…self-medicating myself. It helps me, but it also hurts my pockets- Jaylen 20 y/o male

All the focus group participants who smoke marijuana agreed with Jaylen that smoking affects their finances and that the financial cost is a motivator to decrease or stop smoking.

Further in the focus group, Trey described how while smoking is helpful, this form of coping is only a temporary solution. Trey added to this sentiment by stating:

> It's not going to fix our problems. It's just something we are doing temporarily. Eventually, you are still in the same spot. I don't know what we think we will accomplish by continuing to do the same thing. – Trey 20 y/o male

Overall, clinicians and youth participants typically agreed on the dual function of coping mechanisms. Clinicians realized that the context of community violence exposure altered their perspective on the classification of maladaptive coping mechanisms. Many youths utilized both maladaptive and adaptive mechanisms and often used maladaptive mechanisms until they could find healthier or more effective ways to cope.

Discussion

The findings of this study align with previous literature that suggests that the coping mechanisms that youth employ in the context of community violence exposure may challenge

and defy the traditional understanding of maladaptive and adaptive coping mechanisms (Woods-Jaeger et al., 2020; Edlynn et al., 2008). The findings in this chapter acknowledge that certain coping behaviors that youth employ are helpful and effective in the short- and long-term, while others may be detrimental to long-term health and development. However, the findings in this study also demonstrate that many of the traditionally classified maladaptive coping mechanisms have an adaptive function and that youth often use a balance of both mechanisms. Most notably, avoidance was often discussed as a coping mechanism that had both maladaptive and adaptive properties (DiClemente & Richards, 2022). Through the interviews with clinicians and youth participants, this chapter adds more insight into the function of these mechanisms, which in turn may shift how we categorize them.

Youth in this study described coping mechanisms as behaviors and actions that essentially make them feel better in the context of community violence. For many youth, they reported behaviors that make them feel better by providing a sense of safety such as isolating by staying home. Some of the protective behaviors were also referenced by participants in Chapter Two as survival techniques. While participants referred to some of these behaviors as survival techniques, the literature categorizes them as coping behaviors (Edlynn et al., 2008).

The most reported coping mechanism, music, is a well-regarded therapeutic approach to coping (Flannery et al., 2004). Both clinicians and youth participants agreed that making music or listening to music was a common coping mechanism in this context. Most youth reported they liked to listen to or write raps. More specifically, youth in study expressed having a connection with Chicago artists because their music typically referenced familiar locations or experiences youth participants could relate to. Adolescents often use music to connect and form identities (Miranda, 2013). This evidence could potentially explain why youth participants were so drawn

to Chicago-based artists.

Hip-hop and rap music have been generally associated with influencing violence and aggressive behavior, particularly among Black youth (Chen et al., 2006; Kwon et al., 2021). More recent research recognizes that there can be harmful messages in all genres of music (Kwon et al., 2021). Furthermore, recent research also highlights the evolution of rap and hip-hop music to include more messages surrounding mental health. In this analysis, researchers acknowledge rappers and artists using music as mental health outlets, progressing the conversation on mental health in music (Kresovich et al., 2021). While much of the literature highlights the harms of hip hop and rap music, the findings from this study showed that youth found a great deal of connection in rap music, specifically from Chicago artists who shared their experiences with violence and trauma. Youth were motivated to use hip hop/rap music as a coping mechanism because the messages and references to stressors align with youth experiences of community violence. In clinical practice, some contemporary clinicians have added hip-hop music to their clinical therapy techniques (Dang et al., 2006). Hip-Hop therapy, coined by Dr. Edgar Tyson, is a strengths-based, culturally competent framework inspired to incorporate the culture that people experience into a clinical setting (Tyson, 2002).

The clinicians in this study could define a maladaptive coping mechanism but found it difficult to give specific examples because they could also find supportive evidence to explain why the mechanism could be adaptive. For instance, avoidance and self-isolation have been classified as both maladaptive and adaptive coping mechanisms depending on context and circumstances.

Gang involvement was a critical example of a coping mechanism that was also utilized as a survival technique that had both maladaptive and adaptive functions. Gang involvement is

strongly associated with increased violence, victimization, and other harmful outcomes, such as behavioral and mental health concerns (Connolly & Jackson, 2019). However, as shown in this chapter, gang violence may act as a protective factor for youth against violence (Gilman et al., 2014). In this chapter, many clinicians observed their patients join gangs for protection, support, and financial opportunity.

Understanding coping in the context of community violence is still very variable and nuanced because while the context is the same, children have different levels of access to protective factors or resources that can significantly impact their coping behaviors (DiClemente & Richards, 2022). The literature also suggests that coping is altered by how controllable or uncontrollable youth believe their circumstances are (DiClemente & Richards, 2022; Folkman et al., 1986).

In this study, youth participants with more control over their circumstances utilized fewer maladaptive behaviors than those with less control. Despite this, most youth in this study emphasize avoidance and self-isolation as positive coping mechanisms because they kept them safe from violence even though it hindered their social development and employment opportunities.

The literature on coping often emphasizes the role of emotional regulation in coping. In this study, participants focused on actual actions and behaviors related to coping instead of focusing on thoughts and emotions. For instance, marijuana use was one of the most commonly reported coping mechanisms. Outside of the context of community violence, cannabis and marijuana use are common, especially for people with anxiety. In conjunction with the social stigma decreasing and the legalization of cannabis increases, the prevalence of cannabis use is increasing (Hyman & Sinha, 2008). While many youth in this study utilized smoking as a coping

mechanism, it was also the only coping mechanism that participants collectively stated they wanted to stop. Many youth did not like their dependency on marijuana use.

Furthermore, youth also stated that marijuana was a temporary fix and wanted more long-term solutions. This finding is significant because it provides more nuance into the relationship between youth exposed to community violence and smoking. There is substantial literature on the relationship between youth and smoking, more specifically, smoking marijuana as a coping mechanism (Hyman & Sinha, 2009). For these youth, however, these youth recognized the risks of smoking but also emphasized the harms of behaviors that may arise from being inebriated.

Conclusion

The protective behaviors and coping mechanisms employed by the youth detailed in this chapter are within the context of community violence exposure but also within the larger context of managing uncontrollable stress without proper support. Some participants had opportunities to engage in sports or organizations, but for others, music, marijuana, and avoiding outside were the safest, most effective, and most accessible coping mechanisms.

The implications of this chapter can provide clinicians with further insight into the uncontrollable nature of community violence and the function and necessity of youths coping behaviors. Future research should focus less on the categorization of coping and focus on the nuances of these coping behaviors. A better understanding of how and why youth exhibit certain behaviors will help clinicians better understand how to provide contextually relevant recommendations.

CHAPTER THREE: PERCEPTIONS AND REALITIES: BRIDGING THE GAP BETWEEN YOUTH NEEDS AND EXTERNAL PERSPECTIVES

Community violence exposure is a public health issue that disproportionately affects people of color and individuals living in economically disadvantaged neighborhoods (Nation et al., 2021). Community violence is associated with various adverse social and health outcomes, including psychological disorders, substance use, chronic health conditions, and cognitive challenges (Woods-Jaeger et al., 2019; Linder et al., 2010). In analyzing resilience and community violence, a significant portion of the literature focuses on individual-level protective factors and emotions, actions, and behaviors that youth engage in to buffer or mitigate the impact of the implications associated with community violence. Evidence supports that some person-centered methods, thoughts, actions, and characteristics, such as practicing mindfulness, having self-worth, having hope, listening to music, or being active, can operate as protective factors (Linder et al., 2010). However, from the literature on coping, research has shown that coping mechanisms and individual-level protective factors are contextual, and based on context, the effectiveness of the mechanism can change (DiClemente & Richards, 2022). Furthermore, research has shown that individual-level actions are important, but having access to other resources provides an additional layer of support. Furthermore, research demonstrates that focusing on the culturally relevant resources available to an individual is just as important as individual factors in building resilience (Ungar and Theron, 2020).

Therapeutic Support and Trauma Treatment

Due to the psychological implications of community violence, therapy and other forms of mental health support are recommended to address many of the mental health disorders and

symptoms, such as complex trauma, grief, anxiety, depression, and paranoia often associated with community violence exposure (Foell et al., 2021). Cognitive Behavioral Therapy (CBT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) have been seen as effective treatments for improving trauma-related symptomology and adaptive functioning in youth exposed to community violence (Rudd et al., 2019). A study found that TF-CBT was modestly effective in improving trauma symptoms and the overall mental health of youth with PTSD in Philadelphia (Rudd et al. 2019; Last et al., 2023).

While TF-CBT and other trauma-focused treatment programs work to reduce psychological distress and behavioral symptoms related to community violence exposure, there are many limitations that call for demographic and contextual adaptations to adequately support the respective treatment population (Voisin, 2011). Within the context of community violence, there is still a lot of variability and nuance that can alter how youth are able to navigate, cope, and recover from this form of trauma. Recognizing the effects and implications of community violence brings attention to uncovering forms of support and resources to help assist youth in navigating these traumatic encounters.

There have been requests for more research to evaluate adaptations clinicians employ for assessments, TF-CBT, and other interventions to fit their population (Rudd et al., 2019). The persistent nature of community violence exposure presents challenges to treatment; therefore, there is a great need for trauma-focused treatments and interventions aimed at supporting on-going trauma (Cohen et al., 2011). One documented adaptation has been for clinicians to adapt treatment for past trauma and ongoing trauma (Last et al., 2023). Additionally, adaptations need to be made to address economic disparities, race/racism, and historical trauma (Rudd et al., 2019 Voisin, 2011; Lange et al., 2023). For instance, while researchers and clinicians recognize the

effectiveness of TF-CBT, it is the most effective when youths' basic needs are met (Rudd et al., 2019).

Many interventions and treatments are focused on individual support to address the trauma symptomology associated with community violence exposure (Nation et al. 2021). However, researchers note that the most effective treatments and interventions would be to change youth's context by reducing the violence and trauma that occurs in their community (Luthar and Goldstein, 2004; Edlynn et al., 2008). Overall, addressing the psychological symptoms is not enough. Individuals benefit the most from a multilevel approach that acknowledges the systemic and economic drivers of community violence (Bryant-Davis et al., 2013). To conduct this multilevel approach, the conversation must shift from youth violence prevention to structural violence intervention, emphasizing the behaviors of youth and redirecting it toward the structural factors (Nations et al., 2021).

Structural Violence

Community violence is a structural issue that is the result of various policies and regulations aimed at systemically marginalizing people of color. The roots of community violence are poverty, racism, discrimination, and limited access to health care and education, which are also associated with various adverse health outcomes (Nation et al., 2021). In short, structural violence perpetuates interpersonal and community violence (Hyman et al., 2016). The complexity of this issue furthers the need for a multilevel approach concentrating on what people actually need (Bryant-Davis et al., 2013).

Anthropologist Paul Farmer describes structural violence as:

> "social arrangements that put individuals and populations in harm's way. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people" (Farmer et al. 2006)

Farmer also writes that "the concept of structural violence is intended to inform the study of the social machinery of oppression (Farmer, 2004). The inclusion of Farmer's understanding of structural violence is relevant to this study because it provides the lens through which this research views community violence. Structural violence is a systematic way in which social structures and institutions harm individuals by preventing them from meeting their basic needs (Lee, 2016). Structural violence and racism drive inequity, marginalization, and discrimination, which create deprived communities and fuel community violence (Sharif et al., 2021; Jarvis et al., 2023; Golisch & Tatebe, 2023).

These structural hurdles have a negative impact on mental health and can hinder an individual's resilience (Boyd et al., 2022). As mentioned previously, there are various mental health disorders associated with community violence exposure, such as depression and anxiety (Foell et al., 2021). Examining the association between structural violence and community violence presents additional barriers that exacerbate mental health challenges, such as lack of access to health care and employment discrimination (Sturgeon, 2012). The effects of structural violence continue when there is a societal level of complacency and acceptance of how things are (Montesanti & Thurston, 2015). More specifically, there are various stigmas associated with mental health challenges stemming from structural violence fueled by legislators, policymakers, and government (Sturgeon, 2012; Meagher, 2002; Sayce, 2000).

The Importance of Basic Needs

The public health understanding of structural violence emphasizes how it inhibits individuals' ability to access basic needs (Page-Reeves et al., 2013). The effects of these structural conditions and challenges place individuals at greater risk (Spencer, 1997; Cunningham et al., 2023). Developed by developmental psychologist Dr. Maragret Beale-Spencer, Phenomenological Variant Ecological Systems Theory (PVEST) explores how child development and identity are influenced by the environment by examining risk, vulnerability, and protective factors (Cunningham et al., 2023). The inclusion of PVEST is necessary in this study as it examines the historical context and how exposure to vulnerability influences coping behaviors (Cunningham et al., 2023). Utilizing the theoretical framework of PVEST contextualizes community violence to better understand risk.

There are various forms of risk and vulnerability associated with community violence. As described earlier, mental health support is a common response to the trauma and risk related to community violence exposure, but that is only one avenue to address these concerns. (Bryant-Davis et al., 2013; Nations et al., 2021). Research demonstrates that trauma recovery treatments are most effective when basic needs are met (Rudd et al., 2019).

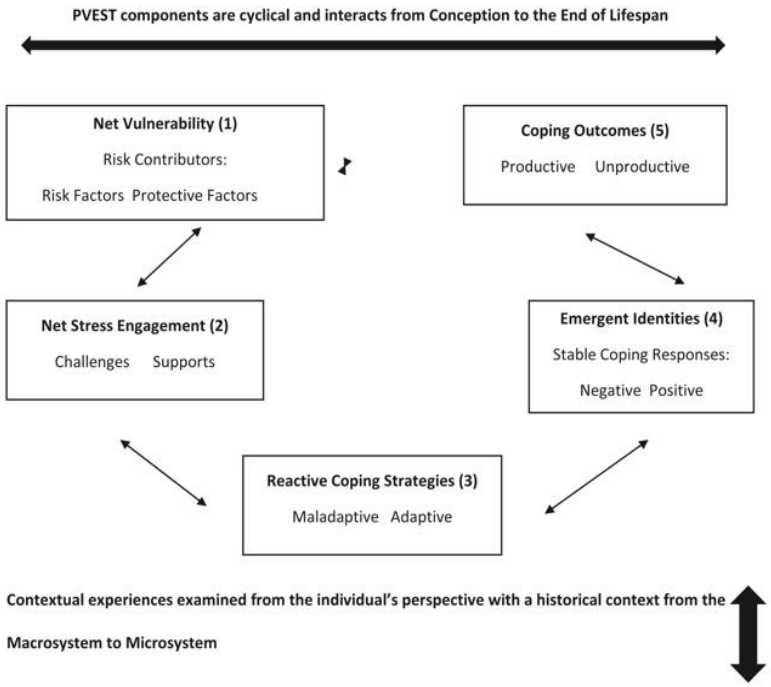

Figure 1: PVEST Components

Maslow's Hierarchy of Needs is a psychological theory proposing that individuals have a hierarchy of needs, starting with basic physiological requirements like food and shelter. If these needs are unmet, individuals may experience negative social, health, and psychological consequences (Kenrick et al., 2010). The evidence in this chapter explains the relevance of this theoretical framework to this research. Under the guidance of Maslow's Hierarchy of needs, there are various complications associated with unmet needs, and individuals impacted by community violence often have unmet needs such as lack of access to safe and stable shelter.

Figure 2: Maslow's Hierarchy of Needs

Housing as an Illustrative Example

Findings from research on structural violence and resilience demonstrated that universal income to access safe housing is instrumental in fostering resilience (Mantler et al., 2024). Considering the complex and structural nature of community violence, access to safe housing is a concern. Housing policies, residential segregation, and predatory lending have all contributed to people's inability to access safe neighborhoods (Foell et al., 2021; Nation et al., 2021). Various interventions are aimed at improving neighborhoods by providing the community with more resources and improved structures. Research has shown a positive association between public housing demolition and affordable housing sites with reduced rates of violent crime (Kondo, 2018). Many cities across the US have adopted programs and policies to reduce violence and address the context by focusing on housing and neighborhood improvements (Hohl et al., 2019). While many of these interventions show promise, there is often data lacking

showing the effectiveness of these plans. One primary concern is displacement, an unintended effect of these changes (Kondo, 2018; Hohl et al., 2019).

Another recommendation is providing opportunities for residents to move outside their current neighborhoods. Due to various factors accompanied by community violence, it can be challenging to design evidence-based interventions to address multiple health and social concerns. Although there is mixed data on the effects of moving, research has shown substantial benefits for youth who can relocate from their public housing neighborhoods (Chyn, 2018; Wendel et al., 2022).

While some interventions and programs show promise, there are also many that do not adequately address the needs of the community. One typical response to violence reduction is increased policing. In a qualitative study on policing in Wisconsin, youth reported that policing reduced the community's safety and prompted more social and mental health services (Wendel et al., 2022).

Overall, various promising interventions and multilevel approaches address structural issues. More research is still needed to evaluate the effectiveness of these plans. Furthermore, the literature lacks gaps that address the relationship between socio-determinants of health and violence. A better understanding of this relationship will help developers and researchers find the best intervention methods (et al., 2021).

This chapter first acknowledges the importance of addressing the psychological implications of community violence exposure and the impact it has on youth development. However, a limitation of focusing on the individual treatment is not fully contextualizing the structural factors that fuel community violence. Violence is not the only issue, and this form of violence is ongoing. Youth are also often experiencing poverty and many other health socio-

determinants that aid in health disparities and inequities. To successfully utilize therapy and other forms of psychological support, we must first understand what youth need in their current context and find ways to provide their needs in addition to mental health support. Through this chapter, we will hear what youth need alongside hearing what clinicians know their patients need to take full advantage of psychological support. Furthermore, we will also hear how clinicians have altered their care and treatment to adapt to the nuances and complexities of community violence exposure.

Methods

Participants for this study were recruited from REACT, a community violence trauma recovery program. Part of this program is the REACT clinic, an interdisciplinary clinic providing trauma-focused interventions and psychological and psychiatric support to families impacted by community violence.

Six clinicians and nine youth participants were recruited from the REACT Clinic. Five of the clinicians were female, and one was male. Six youth participants were male, and three were female, ages 15 to 20. All three of the female participants had witnessed community violence and experienced indirect physical harm. All six of the male participants had witnessed community violence and experienced direct physical harm. More details about the participants can be found in the introduction chapter.

The data analyzed for this chapter explores clinician and youth participant responses to open-ended questions related to youth needs and trauma recovery recommendations. These questions aimed to reveal what clinicians and youth both believe youth need to aid in their trauma recovery and to identify ways to improve treatment.

The complete methods and analysis can be found in the introduction chapter. The first phase of data collection was semi-structured interviews. Before each interview, participants and/or their parent/guardian (for participants under 18) were given a consent/assent form to sign before the interview. Participants were also informed that the interviews were audio-recorded, and their confidentiality was protected. The section of the youth interview analyzed for this chapter asked youth questions about their needs and recommendations for support. The specific questions were:

1) Do you feel like you are adapting well to your exposure to community violence based on the resources you have available to you?
    a) What does adapting well look like to you?
    b) What would you need to adapt better?
2) What resources or supports have you used to help process and recover from your experiences with Community Violence Exposure?
    a) Were these resources or forms of support helpful or unhelpful?
3) What do you wish clinicians/therapists/mental health providers or people studying these issues understood better?
    a) What don't we understand?

The section of the clinician interview analyzed for this chapter asked them to describe their patient's needs and recommendations for other clinicians doing community violence trauma recovery. The specific questions were:

1) What resources have been noted as the most helpful in aiding in CVE mental health treatment?
2) What resources and forms of support do you believe your patients or other youth experiencing community violence need more of?
3) What are some concepts/topics that you think clinicians and other mental health professionals struggle to understand concerning resilience, trauma responses and community violence?

The second phase of data collection was youth focus groups. In this part of the study, youth participants collectively discussed major themes derived from the semi-structured interviews.

Coding and Analysis

This analysis incorporated both inductive and deductive coding. The data was sorted into broad topical categories, starting with deductive coding based on the concepts within the research questions and the interview protocol. The focus was primarily on concepts related to the needs of youth and recommendations for trauma treatment.

Later in the coding cycle, two evaluators conducted inductive coding to develop themes and findings and identify patterns across the interviews and the focus group. A codebook was generated to highlight the most prevalent themes from the interviews and the focus group. All research team members reviewed and provided feedback to finalize the codebook. The prevalence of each theme and subtheme was assessed across the interviews. Selected subthemes from this chapter are listed in Table 3.

Table 5: Subthemes and Example Quotes on Support Needs

Subthemes	Examples Quotes
Helpful Resources	"We have a handout in the REACT clinic that talks a little bit about [community violence] as structural issues, I think that's been really helpful". - Dr. Mario "Well, yeah, I took advantage of the REACT clinic as much as I could. Just anytime anyone was willing to hear, I was willing to talk. I'm not very open like that. So, it was a good experience for me to not only open myself up, but to just address those problems that's eaten away every day. So I took full advantage of that. Also, with my physical therapy as well, just going there as much as I can, learning as many tips and tricks as I could. And using them until I couldn't anymore." - Trey
What Clinicians Don't Understand	"I probably would say you just don't understand systems. I think systems like, broader, organized ways of living, have such an individual impact on people, but

	we don't get how or why. Even like the housing setup of the Southside of Chicago was very intentional". – Dr. Nicole "They try to relate too much. You didn't go through this, you don't know how it feels to sit up and see yourself in the mirror and see what someone who did to your body and couldn't physically do nothing about it"- Miles
Trauma Treatment Recommendations	"They need a safe place to stay. Yeah, so I think that in a perfect world, having a successful, truly successful and effective trauma clinic really necessitates being connected with tangible survival items that we can help patients access."- Dr. Brianna "I feel like they need more in person clinics, different from REACT where people can come in and do family activities and not just answer questions related to research" - Mya
Clinical Training Recommendations	"I've said before, when I was in training, I can't teach someone to deep breathe through a shooting like that's stupid. They need to be able to be the person that they are. So you have to give them the resources to be stable in the environment that they're in." – Dr. Amanda "I was thinking about how we as like black interventionist, and researchers use white methods ourselves because we are forced to and kid ourselves into believing that we are doing something different than what white people are doing, you know, coming up with culturally relevant, culturally based or grounded interventions and theories, but we can't, if we're attached to white methodology" – Dr. Brianna

Results

Youth participants and clinicians all reported that better housing, access to transportation, and money were the most needed resources for youth exposed to community violence. Many participants discussed how a lack of safety and access to these resources influences youth and makes it challenging to pursue other opportunities, such as going to school, getting a job and meeting their basic needs. Clinician Amanda explains it through the following:

> Yeah, definitely poverty, food insecurity. Not always having the best living situations. So, whether that was unstable housing, like they had to transition a lot, or just like their

> homes weren't necessarily in the safest or well-kept areas. I would say, access to transportation was sometimes challenging. I had a bunch of kids who were afraid to take public transportation to get to school, which then made going to school hard. So then that limited access to education because they weren't going to school on a regular basis. What other things I think the other things that I've kind of noticed, particularly with some of my kids is that they would want to work and have money to be able to buy certain things for their families, but then even access to job opportunities was hard. So then it was hard to even meet basic needs because they weren't able to get jobs or maintain jobs stably. - Dr. Amanda

Another clinician furthers this sentiment by also stating that kids exposed to trauma need stable, safe housing and access to money. Furthermore, having a supportive community also makes a difference. She states that kids need:

> To grow and spend their time in extracurricular activities, competitive sports, things that give children structure, some sense of purpose, give them something they come back to every day, and give them a sense of community and mentorship. So just knowing that there's somebody, an adult, some adults who care about who they are, and care about what happens to them. Those are the kinds of supports that make the difference in trauma-exposed kids in my experience. - Dr. Brianna

Housing instability was an adversity that many kids in this study experienced. As clinician Nicole mentioned, many participants moved frequently but often from one unsafe community to another unsafe community. One participant in the study relocated to northern Chicago, where she discussed many positive changes from her move. In her interview, she explains how her old neighborhood was disruptive, but her new neighborhood is quiet:

> It's quiet. Before we moved, it was a lot of violence. gangbangers 24/7, between five to, like, two o'clock in the morning, all you heard was like gunshots to partying, being disruptive. - Dana 15 y/o female

Dana was able to relocate to a safer neighborhood in Chicago, but since many of the youth participants moved to multiple neighborhoods with chronic exposure to community violence, many youth wanted to move away from Chicago. Clinician Mario acknowledges this sentiment and also states how many of his patients want to leave Chicago completely:

> To be honest, I think a lot of them are done in Chicago. I think many of them have expressed the sentiment of wanting to move. Especially for those that have been directly impacted by community violence, it's very traumatizing. I think for folks who have either never indirectly experienced or directly experienced it, it's hard for you to picture it, especially with like, social media and society at large are so desensitized to community violence in Chicago to mass shootings, that it's like, we really don't think about what this means for families. As a clinician who works closely with youth, I can see the pain, I can see the fear, and a lot of them legit just wants to get out. First and foremost, they want to leave and they want their family out of Chicago...In terms of what they need to help with community violence is just more of those classic strategies to or standard trauma focused strategies to help them feel like their bodies not always in pain or on or alert, just wanting to feel more relaxed, I think is some of the common things that I've seen. - Dr. Mario

Access to money through employment opportunities was another theme that contributed to the more prominent theme of escaping community violence through moving. Through this section of the interview, clinicians are discussing opportunities and ways to support youth outside of therapeutic support. Clinician Nicole recommends job support and how the lack of access to employment is related to violence exposure:

> Connecting like young men specifically to jobs has been a huge one. Because part of the reason why they were exposed to violence is often related to meeting economic stability and financial stability. So giving them other options to gain financial resources is important. - Dr. Nicole

As Dr. Nicole recognizes the importance of money, she also acknowledges how financial resources do not fully alleviate the mental health effects of community violence:

> The hard part is like we say that, okay, let's say we give them $100,000. Tomorrow, they're still going to be experiencing the effects of community violence. What we know about rappers and celebrities, who now have the financial resources, they still get shot and killed, right, and so it wouldn't be beyond me that they still experienced the effects of community violence even in a higher social class. So, it's, it's complicated because there are other people that I think have financial resources and still are dealing with the effects of the mental health ramifications of community violence. - Dr. Nicole

Participants described that continuing to live in a neighborhood with violence further engages youth in violence. Because of this, This clinician states:

> A better living environment. Yeah, I feel like the environment as a whole is like, it's like it's like is pulling you towards the violence? Hmm. So as you stay in that environment, you're somehow going to be involved either your fear not directly about you somehow involved. - Dr. Kara

Youth participant Myles stated in his interview how he wishes clinicians understood "how easy it is to give into violence" while living in a neighborhood with elevated rates of community violence.

Money, transportation, and a safer neighborhood were resources youth participants, and clinicians both reported as beneficial for helping youth exposed to community violence. However, as Myles mentioned, there were still many concepts clinicians and other people misunderstood about the experiences and needs of youth living in neighborhoods with elevated rates of violence.

In her interview, Dana expressed that she has lost 26 friends, classmates, and acquaintances to community violence. She states that she wished she had clinicians who had been through similar experiences to get a better grasp of things. She further explained that something that is small to a clinician could be something bigger to youth who have had this experience. She suggested that clinicians:

> Talk about the experiences that aren't always common. A lot of people experience something that maybe little to y'all, but very big to us. I feel like maybe neighborhood friends. So, if you live in a bad neighborhood and there are like, people you grew up with since you were born. Then all of a sudden y'all end up breaking up or something that happened to them? You just start lashing out, and then people just think you're doing it just to get attention or for some other reason. The group of people you lost was the only ones you could talk to, and that is why you don't trust anyone to talk to anymore. - Dana 15 y/o female

Clinicians also gave perspectives on topics people often misunderstand about community violence exposure, treatment, and recovery. Concerning improving trauma care, clinicians had various suggestions for enhancing clinical training and the structure of trauma treatment programs. As clinicians and patients both stated, youth exposed to community violence greatly need access to resources. Dr. Nicole suggests that not being able to provide youth with those resources is a limitation of therapy because even once people recover, they still need access to necessities such as food and shelter:

> It's unfortunate that I think the REACT clinic and clinics like it really serve as a band aid to the broader needs of people. I think we do treat the symptoms and we do treat the lack of connection and that can be very, very healing. And yet, once you're healed from trauma, you still want to know that you can have money beyond just for your food and shelter. The REACT clinic can't really do anything about that- Dr. Nicole

Dr. Briana suggested a clinic model where patients can have access to those resources that aid in survival:

> I think that in a perfect world, having a successful and effective trauma clinic really necessitates being connected with tangible survival items that we can help patients access and having connections with mentorships. - Dr. Brianna

Another commonly reported misunderstood topic was the relationship between community violence and larger systems. Many clinicians mentioned how the complexity of community violence is often difficult to understand, but it is essential for appropriate trauma treatment.

Clinician Amanda describes her challenge with understanding community violence as a structural issue and how to address this within the parameters of therapy. She states:

> I think the whole concept of CV as a structural issue is really difficult to understand. And quite frankly, I'm still learning about how to conceptualize that and what it means for my therapy services. I think that clinicians need a better sense of just definitions around what a structural problem is and what community violence entails. First of all, why it happens or why it's so harmful and why some families are at higher risk than others. Like, why is that happening? Many clinicians may not be thinking about that question. But also, like, what can you do as a clinician to change that? I don't know. I think that clinicians still struggle with trying to balance like, yeah, I have to give an hour of therapy a week. And I'm teaching my kiddos and the youth that I work with these coping strategies, but I'm not getting rid of this big problem of community violence or what am I really doing to contribute to addressing this public health concern? Or what can I do. The knowledge to understand what community violence is, and defining it within the context of these structures, I think is something that clinicians need more training on. And feeling like we can know what to do, or what policy level work we can be a part of, to try and change the environment that these kiddos are coming from, because again, I think as a clinician, if you're just doing this trauma-focused work, it's very critical. It's very important, but you are just putting band-aids on this big one. - Dr. Amanda

As clinicians dive into the complex relationship between community violence and larger systems, they highlight how misunderstanding that dynamic skews how people perceive the behaviors and actions of kids exposed to community violence. Later in her interview, Dr. Amanda further explained the misconceptions about why youth engage in certain behaviors through her understanding of gang engagement. She describes how gang involvement is often a vessel to support kids and their families. She explains how the common perception is that kids want to join gangs, but she argues that some kids see gang involvement as a need:

> I think about the kids in gangs. It didn't start because they wanted to be part of a gang. It started because maybe mom and dad couldn't pay the bills and so they could go get money to run something back and forth from the guy down the street. Then all of a sudden, it becomes like now I'm running other things. It's not always like, hey, let's go join a gang today. Like sometimes, there are reasons for why they did it originally. So, it's not like I wanted to be shooting at other people or like, doing these things like selling drugs. That happened to be the one thing that got me the money that I needed to have the lights on in our house -Dr. Amanda

Recognizing that many behaviors are started out of necessity challenges clinicians' ability to provide recommendations, especially if the behavior has helped the youth maintain their safety. As a youth participant described earlier, clinicians often do not understand the full extent of youth's experiences because they have not lived it. Dr. Briana recognizes that the differences in the lived experiences challenge her therapeutic approach. She states:

> There comes a question me as a therapist, not in that experience, that is not what my home my every day is, who am I to coach you into putting that defense down when that defense is the reason that you're here? And that defense is what saves you? In many situations, it gets you into trouble.

While the REACT clinic and many other programs focus on youth, clinicians and youth patients both recognize the need for more attention to how community violence affects families. Dr. Nicole mentioned how clinicians and researchers often do not understand the full scope of community violence. In her interview, she recommended that people have a greater understanding of how systems impact multiple generations. She states:

> I probably would say you just don't understand systems. I think systems like, broader, organized ways of living, have such an individual impact on people, but we don't get how or why. Even like the housing setup of the Southside of Chicago was very intentional. And I would also probably say, you just don't get intergenerational trauma. The fact that generations after generations have been exposed to chronic stress, and the effect that that has on the next generation. A lot of clinicians will think like, oh, that parent isn't supportive, or they aren't as engaged or they must not care about their child, or they must prioritize other things. It's like they too have untreated trauma and their parents had untreated trauma, so that continues to affect the family and generations after them. I would say those are the main two, like a lack of understanding around systems and then the lack of understanding of the effects of intergenerational trauma. - Dr. Nicole

Other clinicians supported this notion about greater attention being given to understanding how trauma and systems impact generations.

> I think people sometimes think people stay in these situations because they're just not trying hard enough. I think it's hard to understand generational patterns, sometimes, especially when people have broken them themselves. - Dr. Amanda

A youth participant recommended more emphasis on therapy with the children and families. In his explanation, he suggests that therapy with the parents is necessary because they also have many challenges:

> I feel as though if there has to be therapy with a child, there should also be therapy with a parent or parents. Because sometimes parents wasn't grown up right, either. They only going off what it is they was taught or had to learn, they excelled. I look at that with my mother as well, because she didn't have her father present. And just not having as much support is needed. That's when I learned about perspective. It helps me not to bump heads with my mother, because I was like, I have to understand she grew up a certain way, you had to do things a certain way, just as well as me. It's just being very considerate. If a therapist was to know like, oh, okay, their parents are like this, because of this. Now, I see why their child feels like this. Oh, well. – Jaylen

Throughout this chapter, youth and clinicians describe how stable, safe housing, transportation, and money are critical resources for helping youth exposed to community violence. These resources serve as vessels to other opportunities such as school, jobs, extracurricular activities, and sports. Furthermore, clinicians highlight limitations in trauma clinics and how those resources could better support trauma treatment.

Discussion

As youth and clinicians described things that kids exposed to community violence need, none of those suggestions included additional therapy or psychological support. All the recommendations were resources to help youth meet their basic needs. A few clinicians highlighted that even with proper therapy, the lack of access to these resources still makes trauma recovery challenging. Some recommendations included having more resources readily

available for trauma clinics, like a food pantry or opportunities to connect patients and families with resources like housing vouchers. These findings are consistent with previous research highlighting the limitations of mental health support without additional resources to help youth meet their basic needs (Rudd et al., 2019; Last et al., 2022).

While youth and clinicians both understood the importance of tangible resources to aid in survival and trauma recovery, there were still aspects of community violence that youth and clinicians felt other clinicians and people did not understand. For youth, part of this misunderstanding is grounded in clinicians not having the same lived experience and not understanding the full extent of living in a neighborhood with elevated rates of community violence. While violence is a prevalent aspect, there is also poverty, lack of access to food, accessible transportation, and limited job opportunities. These additional adversities also influence the health and well-being of youth. This evidence aligns with research on the mental health implications of structural violence and how it inhibits people from accessing proper survival resources (Sturgeon, 2012; Page-Reeves et al., 2013).

Many clinicians mentioned that understanding the systems and structures that fuel violence impacts trauma treatment. However, a lot of mental health providers still struggle to fully understand the complex relationship between structural issues and community violence and how it shapes youth behaviors. As a clinician mentioned, through gang involvement, she described how people often assume that kids want to join a gang. However, through her experience with trauma treatment, she recognizes that this action is motivated by the need to have things such as food and money. In previous chapters, this paper discusses how literature defines behaviors such as gang involvement as maladaptive (Frisby-Osman & Wood, 2020). However, many clinicians in this study have argued that examples of kids joining gangs are

contextually adaptive behaviors. In turn, this alters trauma treatment because clinicians are then tasked with reassessing their treatment and therapeutic approach due to the chronic stress and uncontrollability of the environment that is essentially forcing youth to engage in maladaptive behaviors.

A part of understanding the complexity of CVE is recognizing how this affects not only youth but also the implications of CVE, which are long-term and often impact multiple generations. Therefore, clinicians recommend that attention be given to parents and other members of the family because it is expected that more than one family member has experienced trauma or chronic stress. A few youth participants suggested opportunities for parents and their children to be involved in therapy.

Conclusion

This chapter's findings show a need for tangible resources with psychological support to aid in trauma recovery. Furthermore, youth and clinicians highlight the limitations of trauma clinicians and clinics. One major request, primarily from clinicians, was to ensure that other trauma clinicians are comprehensively trained and educated in the complexity of community violence because not having that training and education could detrimentally alter the support clinicians offer their patients.

This chapter's implications can potentially impact clinical training and trauma recovery programs. The data demonstrates that youth’s basic needs must be addressed in addition to psychological support for the most effective trauma treatment. This conjunction of basic needs and psychological support could potentially be given in the same space through a multilevel program or clinic. Furthermore, this chapter highlights the complexity of community and

structural violence. Ensuring that trauma recovery clinicians understand how structural violence influences mental health and wellbeing, as well as decision making, can greatly alter clinical treatment models and psychological recommendations. This chapter adds to the literature by adding more nuance to understanding how clinicians, trauma treatment developers, researchers, and policymakers may intervene.

CONCLUSION

This dissertation details and analyzes youth's physical and mental navigation through community violence exposure in Chicago through the perspectives of youth and trauma clinicians. This analysis identifies differences and parallels in youth and clinicians' understandings of how youth make meaning of their environment and the tools they utilize to cope, adapt, and survive.

As detailed in the introduction chapter, substantial research examines the relationship between resilience and community violence exposure. Resilience can be a protective barrier against the health implications of community violence (Copeland-Linder, 2010). Traditional notions of resilience emphasize rebounding from trauma or returning to pre-crisis status, but this notion is challenged when applied to contexts of continuous exposure to community violence (Woods-Jaeger et al., 2020). Individuals in neighborhoods with high rates of community violence endure a series of traumatic events rather than recovering from a single isolated incident. Studies on resilience in Black youth exposed to community violence suggest a need for contextually relevant understandings of resilience that acknowledge the unique circumstances and coping mechanisms emerging in the face of continuous trauma (Woods-Jaeger et al., 2020). This shift in approach recognizes the limitations of traditional resilience frameworks and highlights the importance of tailoring resilience concepts to address the complexities of ongoing adversity.

Shervin Assari, a prominent public health scholar, explores the nuanced relationship between Black individuals and resilience, elucidating how historical experiences of structural racism have equipped them with coping mechanisms and adaptive behaviors. Through both public and academic scholarship, Assari suggests that frequent exposure to stressors among

Black communities has led to habituation and enhanced adaptation to adversity (Assari & Lankarani, 2016). His research highlights that while Black individuals face more life stressors, they exhibit remarkable resilience, experiencing fewer adverse mental health outcomes despite the challenges they encounter. Studies have indicated that while white men may face fewer stressors, these stressors have a more significant impact on their mental well-being compared to Black men, reflecting the contrasting ways in which stress manifests across racial groups (Assari & Lankarani, 2016).

While Assari's scholarship offers an optimistic perspective on Black resilience, it also prompts a deeper exploration into the complexities of racial disparities in mental health outcomes. Although Black individuals demonstrate lower rates of depression and psychological distress, there remain significant gaps and discrepancies in the data. While their adaptability to adverse circumstances may mitigate some mental health risks, the enduring effects of chronic stress on overall well-being warrant further research (Williams, 2018; Assari & Lankarani, 2016). The intricate relationship between race, resilience, and mental health emphasizes the need for more nuanced research and interventions to address the multifaceted challenges faced by Black communities in navigating systemic inequities.

This project also explores coping mechanisms and resilience, acknowledging their distinct yet interconnected roles in navigating adversity. Coping mechanisms serve as strategies for handling stressors, with racial and cultural differences influencing individuals' responses. Protective factors within neighborhoods, such as quality schools and support systems, play a crucial role in fostering healthy coping behaviors and mitigating the impact of trauma. Moreover, the development of resilience extends beyond individual capacity, involving factors like

community support and cultural context, highlighting the importance of considering broader environmental influences.

The literature emphasizes the evolving understanding of resilience, particularly within marginalized communities facing chronic stressors like community violence. It emphasizes the necessity of contextualizing resilience research within cultural and environmental frameworks, acknowledging how individuals challenge traditional notions of resilience through their adaptive responses to ongoing trauma. By exploring the nuanced relationship between culture, context, and resilience, the research provides insights into how Black youth navigate and adapt to the persistent adversity of community violence exposure, contributing to a more comprehensive understanding of resilience in diverse contexts.

This project aims to explore the experiences of youth residing in communities with heightened levels of violence, examining how they adapt and challenge conventional notions of resilience. It seeks to explore the protective factors, trauma responses, coping mechanisms, and survival strategies employed by these youth. The primary objective is to understand the dynamic nature of resilience, which shifts based on varying circumstances and contexts, with a specific emphasis on trauma resulting from community violence.

To achieve this goal, the research has addressed several key questions:

1) What does resilience look like in the face of exposure to community violence?
2) What are the differences between survival, resilience, and adaptation?
3) What does it mean to "adapt well" to community violence or continuous traumatic stress?
4) How does youth exposed to community violence demonstrate duality in maladaptive and adaptive coping mechanisms?

I examined these issues by focusing on clinicians and youth participants living and working in Chicago. The participants of this project are from REACT, a community violence trauma recovery program. The sample included six clinicians from various stages in their

careers. The youth participants included three females and six males. All of the male youth participants had witnessed community violence and experienced direct physical harm. More details about the participants can be found in the introduction chapter.

In chapter two, I examine how resilience in the context of community violence defies the traditional understanding of resilience due to ongoing trauma, lack of access to resources, and the presence of other forms of adversity, such as food insecurity and housing instability. In this chapter, I argue that for youth and clinicians, resilience is synonymous or interchangeable with surviving. The process of recovery was challenging for youth, so they often relied on survival techniques that clinicians regarded as mechanisms that should be used temporarily. However, the youth recognized these behaviors, kept them safe, and repeatedly used them even without the clear presence of a threat or danger. Because of this, clinicians became supportive of the use of survival techniques that then turned into adapted behaviors because clinicians recognized the dire need for these protective behaviors. Furthermore, I found that the literature lacks a description of the complexity of surviving in the context of chronic community violence exposure. For many of these youth, staying alive was a daily challenge, and many of their behaviors were related to maintaining safety and securing their basic needs.

In chapter three, I explore coping mechanisms classified in the literature as maladaptive and adaptive. For clinicians, they described how their formal psychological training understanding of coping mechanisms differed from their current understanding through trauma work. The clinicians often could argue for reasons why certain behaviors, such as gang involvement, drug use, and isolation, had adaptive components. In this chapter, I discuss how behaviors typically classified as maladaptive are contextually adaptive. I found that even though some of these behaviors may come with consequences, the consequence of not engaging may be

more detrimental than engaging. Youth also often used both maladaptive and adaptive behaviors until they could engage in more healthy or effective coping behaviors. Additionally, youth were often very aware of the potential harms of certain behaviors but recognized that these perceived maladaptive behaviors were often the best and most accessible option.

Finally, in chapter four, I compare what youth need to what clinicians believe they need. Collectively, both youth and clinicians agreed that accessing basic needs is instrumental in trauma recovery. In this chapter, I argue how therapy and mental health support directly address trauma symptomatology. Still, there are various other challenges and health disparities associated with living in a neighborhood with elevated rates of violence. These additional adversities, such as housing instability and limited transportation, make trauma recovery more complex. In addition to basic needs, both youth and clinicians argued for a more complex and in-depth understanding of community violence as a structural issue. Clinicians acknowledged how understanding structural violence and racism as the root of community violence is essential to informing and transforming trauma treatment.

The findings from all three papers show a large consensus among youth and clinicians regarding the impact and influence of community violence exposure. The findings further reveal clinicians' thorough understanding of this impact, which emerged from their professional experiences rather than their formal academic training. This revelation is related to clinicians' recommendation for other clinicians and trauma workers to have a better understanding of the systems that fuel community violence because it, in turn, impacts their treatment. Recognizing that community violence is not just random violence but also accompanied by many other public health issues explains why many youths have challenges adapting to traditional adaptive coping behaviors. Understanding the nuances of community violence exposure can better inform how

clinicians develop trauma treatment adaptations.

One of the significant components of community violence is the ongoing nature of this form of trauma. Several trends that emerged across the data were related to ways youth had to combat multiple forms of trauma and adversity at once with little access to support or alleviation. For instance, the survival mechanisms that youth employ are utilized almost daily because their environment presents various threats. Therefore, youth became accustomed to behaviors that provided safety, but they also recognized that these behaviors may not function similarly in other environments. So, as these behaviors worked well in this environment, their function became detrimental as youth attempted to maintain them at school or in a work environment.

This dissertation aims to provide insight into the complex nature of community violence through the lens of people experiencing and treating this form of trauma exposure. Through the experiences of youth, this research examines the strategic behaviors and mechanisms youth employ to maintain safety and survive. While this paper focuses on the experiences of youth, it is not focused on the actions of youth but more on the environment that forces youth to make such dire decisions. This dissertation opened by attempting to situate these youth in the traditional conceptualization of resilience. The findings demonstrate that we may be confusing resilience with survival. Resilience is an active adaptive process, and many of these youth are showing a life of survival. However, other youth are finding contextually positive and effective ways to adapt to their environments through maintaining safety and being active participants in various spaces such as school and their family life. More importantly, this dissertation prompts us to think about the environment in which we ask youth to live and recover simultaneously. Our attention must shift from youth's survival actions to creating environments where they can thrive. I recognize that to be a significant step that would require the dismantling of many systems that

are fueled by racism and discrimination. However, in the meantime, researchers should continue to make trauma treatment adaptations and find ways to allow youth to receive many of their essential needs and psychological support in the same space.

This study has various limitations, and not all of the findings may not be generalizable. One primary limitation is the sample size of this study. All of the participants are recruited from the same site, which may influence some of their responses and experiences. Furthermore, the sample size of the youth participant group is small, considering the overall size of the clinic. Due to the systemic inequities many families faced in the REACT clinic, participating in a research study was challenging.

The clinicians in this study are in various stages of their careers and some of them are still in training as they have not completed all their requirements for licensure. This method provides insight into how clinicians are trained at different levels but also may serve as a limitation.

The future of this work has several policy and practice implications. The first is that this work has the potential to influence clinical training. The recommendations that clinicians and youth provided bring attention to ensuring the structural nature of community violence is at the core of treatment. Furthermore, participants desire interventions that are culturally and contextually relevant. This finding can support the quest for more trauma treatment adaptations. Lastly, the evidence from this project can support justice reform, as this work examines gang involvement and substance use as coping mechanisms. These behaviors are in response to systemic failures and this project highlights how these responses aid in trauma recovery.

Appendix 1: Interview Protocols

If I was an alien who just landed on earth but somehow spoke perfect English and they asked you to tell them about life in the USA what would you tell them? And what would you tell them to describe life in the neighborhood that you grew up in? And finally, what would you tell them to describe the high school that you attended?

Now, what would you tell that alien to help them understand who you are; what would you tell them about yourself?

1. Could you please share how you became involved with the REACT Clinic?

    a. What was your experience like at the REACT clinic?
    b. What did you do?
    c. What did you learn?

Follow up: I would like to ask you some questions about your experiences with community violence?

2. As you think about your experiences with community violence, how have they shaped your life/ how have they impacted different parts of your life?

    a. Relationships/ Friendships?

    b. Health habits (sleeping, eating, substances)?

    c. Social habits (schools, sports)

3. How are you adapting to your experiences with community violence? What would you tell that alien about how you have managed to cope with your experiences of community violence?

4. What are some things you have done differently because of your experiences with community violence?

    a. Navigating relationships/ Friendships?

    b. Change in health habits (sleeping, eating, substance/alcohol use)?

    c. Social habits (schools, sports)

    d. Could you share why you began to do these things?

5. Describe some things you did to cope with your exposure to community violence?

    b. What makes these mechanisms/things positive or negative?

5. Tell me about some of the things that you have done to help process and cope with your experiences of community violence?

a. Things you have done

b. Things other people have done for you

c. What resources did you use? (Community resources,

therapy, medication)

d. What was the most helpful

e. What was the most harmful

6. Have you ever heard of the word resilience?

a. If not, *read/explain the definition of resilience*, based on this definition, how does resilience apply to you and your experiences?

b. If so, tell me what resilience means to you

c. Describe how this may apply to you and your experiences

7. Do you think resilience is a positive or negative thing/ good or bad

8. Do you think that you are resilient or have shown resilience?

a. If so, describe a time or a situation that you have demonstrated resilience

9. From our discussion what is the difference between being resilient to community violence, adapting to community violence and using survival techniques?

Note: use this question in focus group

10. Do you feel like you are adapting well to your exposure to community violence based on the resources you have available to you?

11. What does adapting well look like to you?

12. What would you need to adapt better?

12. What do you wish clinicians/therapists/mental health providers or people who are trying to help people who have experienced violence understand better?

What is it that they often get wrong?

13. Is there anything we have not discussed that would help me fully understand how you experienced and coped with community violence?

Clinicians semi-structured interview guide

14. Describe your current role and role at the REACT Clinic?

15. How did you become involved with the REACT clinic?

16. What makes the REACT clinic different from other programs/clinics?

17. Given what you know now, how well do you feel that your academic and professional training prepared you to work with patients exposed to community violence?

18. Describe the patient population you see at the REACT clinic?

a. Age, race, education/occupation
b. Neighborhood
c. Types of trauma/adversity
d. Types of exposure to violence

19. What are some of the most common ways you see community violence affecting your patients?

a. Common trauma responses
b. Common survival technique

20. From your observations, what are common coping mechanisms patients may have used before their treatment at the REACT Clinic or other trauma clinics?

a. Which mechanisms would you classify as maladaptive or adaptive?

21. From your experience, what does resilience look like for youth exposed to community violence?

22. How do you define resilience?

23. How do you feel about the word resilience?

24.Do you/would you refer or classify your patients as resilient? Why/why not?

24. How does resilience manifest in the presence of CVE and complex trauma?

25. What factors have you observed contribute to the resilience of youth exposed to community violence?

26. What ways have you recognized your patients attempting to adapt to CVE?

27. What resources have been noted as the most helpful in aiding in CVE mental health treatment?

28. Describe some survival techniques that you see patients use after their exposure to community violence?

29. What would your patients say they need more of in forms of support or things to help aid them in this process?

30. Based on your experiences, how well do you think trauma clinics such as REACT are able to address the needs of patients exposed to community violence?

31. What are some concepts/topics that you think clinicians and other mental health professionals struggle to understand in relation to resilience, trauma responses and community violence?

32. Anything else you would like to share

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