Designing Accessible Mental Health Care in an Urban Community: Lived Experiences of Key Stakeholders Planning Emergent Community-Based Services

Matthew Walsh

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DESIGNING ACCESSIBLE MENTAL HEALTH CARE IN AN URBAN COMMUNITY: LIVED EXPERIENCES OF KEY STAKEHOLDERS PLANNING EMERGENT COMMUNITY-BASED SERVICES

A Dissertation Submitted to the
Executive Doctoral Program in Counselor Education and Supervision
Graduate School of Education

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
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August 2015
DUQUESNE UNIVERSITY
SCHOOL OF EDUCATION
Department of Counseling, Psychology and Special Education

Dissertation
Submitted in Partial Fulfillment of the Requirements
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ABSTRACT

DESIGNING ACCESSIBLE MENTAL HEALTH CARE IN AN URBAN COMMUNITY: LIVED EXPERIENCES OF KEY STAKEHOLDERS PLANNING EMERGENT COMMUNITY-BASED SERVICES

By
Matthew J. Walsh

August 2015

Dissertation supervised by Lisa Lopez Levers, Ph.D.

Disparities in mental health care between African Americans and Caucasians have increased significantly since the 1990s, and social determinants such as poverty, access to resources, education, institutionalization, and housing status can have an additional negative influence these disparities (Hunt et al., 2013; McGuire & Miranda, 2008; Primm, et al., 2010). This suggests that further research is needed to identify and examine the “malleable barriers,” that is, research that better explains the pervasive racial disparities in the current healthcare system. This community-driven phenomenology-oriented study employed a multi-method approach, primarily the consultative workshop method (Levers, 2003), a form of participant action research, to describe the lived experiences of urban key stakeholders’ experience of community trauma and barriers to healing and recovery.
These exploratory research findings suggest five main contributing risk factors/themes that inform a better understanding of community trauma and the help-seeking process. The five factors/themes are stigma, chronic community violence, social determinants, racism, and transgenerational or historical trauma. The inquiry aimed to capture the lived experience of community trauma in an urban environment. In doing so, the investigation found that the collective and overt nature of multiple types of traumas, as experienced across the life span, can be understood more fully from a community context. This study proposes a new model for addressing the needs of a racial/ethnic trauma-informed community. Adding to the current trend of “integrated care” and “trauma-informed approaches,” the idea of community development was integrated into a trauma-informed approach. The trauma-informed community development strategy produced from this study suggests a paradigm shift from focusing behavior health interventions solely upon the individual, to focusing interventions on the environment, in order to mitigate the effects of community trauma and to build resilience.
DEDICATION

This dissertation is dedicated to the men and women of FOCUS Pittsburgh and the Hill District who work tirelessly for community healing, transformation, and social justice. You have inspired this project and me. Thank you.
ACKNOWLEDGEMENT

There are so many people throughout my life who have given me opportunities to imagine the “possibilities” and provided fertile ground for growth and recognition of my full potential, I cannot name them all here. To all those people who walked with me, shared their life with me, and encouraged me along the way, I am deeply grateful.

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To my wife, Dr. Jane Walsh, you inspire me every day. You have supported me throughout this whole process and gave me confidence when needed; without you I would have never finished. I am deeply grateful for your countless hours reading,
rereading, and providing feedback on my papers throughout my graduate programs; I am forever thankful. To my daughter Josephine who was born during the orientation of this program, you inspire me every day to be the best I can be and to “slow down” and be present in the moment. To my family back in California, I would never have been able to pursue my education without your love and support. I owe a special thanks to my good friend Tony Cuda. Thank you for the countless hours reading my dissertation and offering helpful editing suggestions, and in record timing!

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Chapter 1: Introduction

Pittsburgh’s Hill District is an extraordinary African American community. The Hill District, commonly referred today as “the Hill,” has had a storied and challenging history, one that has been mixed with cultural and economic vibrancy, as well as external and internal factors influencing its decline in the 1960s. The Hill originally was composed of three separate neighborhoods, identified as the “lower, middle, and upper hill.” The lower hill was called “Hayti” and was populated by runaway slaves in the early 1800s. The middle hill was called “Lacyville,” and the upper hill was called “Minersville” or “Sugar Top.” Germans and Scotch-Irish primarily inhabited the middle and upper hill until the 1880s, when central and Eastern Europeans arrived (Toker, 1986). Over the years, the three neighborhoods have merged, at least figuratively, into a singular conceptual space that today is known as “the Hill.”

African Americans from the South started to migrate to the Hill in the early 1900s. The Great Migration around WWI substantially increased the Hill population with the promise of jobs and relief from segregation laws in the South. Conditions in Pittsburgh did not live up to the promise. African Americans were segregated from the White world of the wealth and power of downtown Pittsburgh (Brewer, 2006). During this same time period, Russians, Slovenians, Syrians, Greeks, Armenians, Poles, Jews, and Chinese settled in the Hill, creating a diverse integrated neighborhood. The influx of immigrants to the Hill provided the building blocks for a vibrant cultural hub and thriving business community. By the 1940s the Hill was almost entirely populated by African Americans (Toker, 1996). Out of necessity, African Americans in the Hill developed strong institutions of their own, including Churches, emergency services, pharmacies,
schools, and periodicals like the *Pittsburgh Courier* newspaper. The *Pittsburgh Courier* newspaper became one of the premier national Black news sources and is still in existence today. From the 1930s to the 1950s, the Hill was one of the most successful, safe, thriving, and prominent Black neighborhoods in America. It was considered a center for Jazz music, art, and literature. This time period is often referred to as the “Wylie Avenue Days.” In a New York Times article, a resident of the Hill for more than 50 years stated, “The Hill was a conglomeration of everything and everybody… It was Black people running their own lives, and we loved and cherished it because it was all we had” (Clemetson, 2002). This quotation illustrates the autonomy and resourcefulness of the Hill community as well as the prevalence of racism and segregation that existed in Pittsburgh and throughout the country.

In the 1940s the Hill was a thriving neighborhood, but the infrastructure of the lower Hill was considered to be of poor quality. Pittsburgh city officials saw an opportunity to cash in on federal dollars in the name of urban renewal. George Evans, a City Council member in 1943, wrote, “approximately 90 percent of the buildings in the area [lower Hill] are sub-standard and have outlived their usefulness, and so there would be no social loss if they were all destroyed” (Evans, 1943). The idea that there would be “no social loss” is indicative of the time period and an example of institutional racism that the residents experienced on a daily basis. In 1955 the federal government approved loans for the redevelopment of the Lower Hill, and in 1956 approximately 1,300 homes and buildings residing on 95 acres were demolished to make room for a proposed performing arts theater, which eventually became a sports arena. The redevelopment displaced more than 8,000 residents. The decline of the Hill continued into the 1960s,
concurrent with relevant national events like the assassination of Dr. Martin Luther King Jr and the ensuing race riots in 1968. Many middle class African Americans moved to other neighborhoods. The Hill continued to languish during the 1970s, the crack epidemic hit the Hill in the 1980s; and by the 1990s the Hill’s population declined from more than 50,000 in the 1950s to 15,000 (Clemetson, 2002).

Like many urban minority neighborhoods throughout the country, the Hill suffers from poor infrastructure, homelessness, poverty, a lower social and economic status (SES), chronic community violence, and high unemployment, all of which combine to leave the community fragmented and distressed (Krivo & Peterson, 1996). Recently, the resilience of residents there has brought forth renewed development in housing, businesses, and social services, but the effects from the aforementioned systemic problems have had lasting negative consequences, which have affected the physical, mental, social, and spiritual well-being of the Hill community. As this brief history of the Hill illustrates, racism, discrimination, segregation, low SES, and lack of opportunity to access the full benefits of the city of Pittsburgh or our society at large have been a part of the Hill community’s experience since the Great Migration. The residuals from the heritage of slavery have been transmitted through generations and manifested into present forms of discrimination, with negative stereotypes contributing to racial and ethnic health disparities (Sotero, 2006). Further, the legacy of slavery has impacted both the physical and mental health of African Americans (Atkinson, Nelson, & Atkinson, 2010; Estrada, 2009; Williams, Neighbors, & Jackson, 2003).

In January of 2013, I was invited to be on a panel and planning committee to create an intentional conversation around the topic of community trauma in the Hill. This
conversation was part of a lecture series sponsored by Duquesne University. At our first meeting, I met Mr. Paul Abernathy, the Director of FOCUS Pittsburgh (FOCUS), along with a psychiatrist who volunteered his services at FOCUS. The community conversation took place at the YMCA in the Hill. Hill residents as well as Duquesne University students, faculty, and staff attended the deliberative dialogue. The panel consisted of two women (Residents of the Hill), a police officer, a local Pastor, a psychiatrist, and me. The conversation became a vehicle for intimate personal testimonies about how trauma has affected the lives of residents and their community, as well as for the emergence of medical and social justice perspectives related to community trauma. The narratives shared at this dialogue were unscripted, authentic, and represented raw, lived experiences from a variety of perspectives. These stories described the layering and transactional nature of trauma experiences present in the Hill environment. In addition, the deliberative dialogue was an opportunity for consciousness raising for the community and the University. Little did I know at this point that this encounter and participation would become the catalysts for this research project. Before we move forward, a brief background about FOCUS Pittsburgh is warranted.

**Focus Pittsburgh**

FOCUS Pittsburgh is a faith-based non-profit entity and a part of FOCUS North America (FOCUS NA), which is a movement within the Orthodox Christian Church. FOCUS stands for *Fellowship of Orthodox Christians United to Serve* and was founded in 2009. FOCUS NA has over 50 operations and seven centers throughout the United States. FOCUS stands for Food, Occupation, Clothing, Understanding, and Shelter. FOCUS NA identifies its mission as “action-oriented” and actively seeks sustainable
solutions to poverty by investing in social and human development services. Theodora Polamalu, an advisory board member for FOCUS NA, initiated FOCUS Pittsburgh in 2011. Over the last 4 years FOCUS Pittsburgh has established itself and integrated its services into the Hill community. FOCUS offers a variety of community-based programs. These programs range from living assistance programs, educational and entrepreneur, to the newly established FOCUS Pittsburgh Free Health Center (FPFHC). The FPFHC opened in the summer of 2014. The objective of the free health center is to address health-related disparities in the Hill. Central to this objective is a trauma-informed approach to well-being. Examples of programs offered by FOCUS include: employment/transportation/housing assistance, emergency relief funds, benefit enrollment, furniture and clothing, food pantry, backpack feeding program for local schools, community building programs, professional development academy, and micro-business opportunities.

As a continuation of the deliberative dialogue at the YMCA in March of 2013, FOCUS staff, volunteers, and I began initial steps for planning the FPFHC. During the first committee meeting at FOCUS, which I attended in the fall of 2013, community members on the committee were asked to define community trauma in the Hill. Group members presented various opinions from personal experiences and from living in the community for many years. Community members differed on specifics and possible primary causes influencing the idea community trauma. During an email exchange between Mr. Abernathy and me, in the summer of 2013, he provided a framework for community trauma that sums up the complexity and layering of trauma experiences in the Hill. Mr. Abernathy described community trauma as:
A shared experience of suffering that characterizes the personal experiences of many in the community. Chronic unemployment, crime, drugs, homelessness, hunger, abuse, poverty, and most profoundly brokenness and radical isolation have all created a culture informed first and foremost by trauma. For this reason, trauma is the foundation upon which the community worldview is laid (P. Abernathy, personal communication, July 2, 2013).

Mr. Abernathy’s articulation of community trauma became the working framework for my research project. This naturalistic framework highlights the complex interwoven web of possible systemic issues/variables influencing disparities in mental health treatment and the overall well-being of the Hill community. It describes a collective experience of “suffering” that can influence negative meaning-making processes in self and in the community. In addition, this conceptualization of community trauma became the operationalized definition for the term “trauma-informed community.”

**Mitigating Community Trauma as the Inspiration for the Current Project**

The idea for this study emerged during my participation in the initial meetings for the FPFHC and the deliberative dialogue that ensued. It was clear from these initial meetings that the idea of community trauma and the issues with which it is interwoven was complex and layered. I suggested to the group the idea of having a consultative workshop, which has been employed by the World Health Organization (WHO) around the world to generate culturally sensitive community-based services to address a variety of health-related issues (Levers, 2003). The consultative workshop is essentially an extension of focus groups. This workshop would help to problematize the idea of community trauma, help to define it in the community context, and have the potential to
produce community interventions that can aid in the healing process. I offered my services to help plan the consultative workshop with the FOCUS staff and volunteers. I would analyze the data generated from the workshop as part of my dissertation and aid in the planning and implementation of community-based services.

My research project fulfilled a real need for FOCUS. The consultative workshop method is a form of participant action research (Levers, 2003). My study, from conception to the end of this formalized study, was collaborative and community driven. The data generation and findings happened quickly, with the deliberate intention of informing the application of community-based services. This approach to the research project lead to a “horizontal rather than a vertical pedagogical model,” creating a non-hierarchical intentional design and space for shared knowledge building, for the purpose of creating community-based services (Levers, 2003). From December 2013, I collaborated with FOCUS staff, volunteers, and my committee chair in designing and executing the consultative workshop on April 26, 2014. After the consultative workshop, the data generated from the focus groups led to initial findings regarding barriers to treatment, protective and risk factors associated with help-seeking processes, creating a common framework for understanding community trauma, and informing emergent community-based programming and interventions.

**Background of the Problem**

National surveys (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Kataoka, Zhang, & Wells, 2002; Kessler et al., 1994; SAMHSA, 2013) have shown that approximately one in five Americans will have a mental health problem in any given year, but only one in three will receive or seek mental health services. Furthermore, “of
the 45.9 million Americans 18 and older who have mental health conditions, just 17.9 million receive treatment” (SAMHSA, 2013). These statics are even greater in racial/ethnic minority populations. In a recent study by the Center for Disease Control, disparities between Whites and Blacks in behavioral healthcare treatment have increased significantly since the 1990s (Primm, et al., 2010). The Minority Health and Health Disparities Research and Education Act of 2000, defines disparities as, “differences in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival.” The research suggests that social determinants may influence disparities in minority populations. Some of these social determinants include poverty, access to resources, education, institutionalization, and housing status (Primm, et al., 2010). Racial/ethnic minority populations are more likely to experience low SES, which significantly has been linked to mental illness (Karlsen & Nazroo, 2002). The U.S. Census predicts that, by 2042, racial/ethnic minorities will surpass Whites as the majority population, yet minority populations have remained underserved in the current behavioral healthcare system (US Department of Health and Human Services, 2009). The research literature has clearly indicated that disparities exist within the current mental healthcare system for racial/ethnic minorities, and below, I introduce the reader to potential barriers to treatment. In addition to barriers to treatment, mental health disparities are also the complicated result of further, adverse experiences such as interpersonal violence, victimization, social determinants, and racism experienced by many Hill residents. All of these factors help to shape the idea of a trauma-informed community.
Stigma

Research on barriers to mental health services, specifically with racial/ethnic minority groups has reported inconsistent results. One overarching barrier to treatment that has received attention in the literature is perceived stigma toward individuals with mental health illnesses and treatment within racial/ethnic populations. Some research posits that African-Americans, Latinos, and Asian Americans hold more stigmatizing attitudes toward individuals with mental illness than non-Latino Whites (Anglin, Link, & Phelan, 2006; Fogel & Ford, 2005; Rao, Feinglass, & Corrigan, 2007; De Crane & Spielberger, 1981). However, other studies found no difference or positive attitudes towards individuals with mental illness (Diala et al., 2001; Furnham & Andrew, 1996; Givens et al., 2007; Sheikh & Furnham, 2000). When specifically looking at African Americans, Jimenez, Bartels, Cardenas, and Alegria (2012) found no significant differences in attitudes toward stigma between African-Americans and non-Latino Whites. Additionally, the authors reported adult African Americans had more “comfort” in discussing mental health issues with primary care physicians and mental health professionals than non-Latino Whites (Jimenez et al., 2012). It is worthy to note that this study was conducted with populations actively in treatment, a fact which may have influenced results. Given that research shows inconsistent results associated with attitudes and/or beliefs toward barriers to treatment in racial/ethnic minority groups, and empirical research shows significant racial inequality regarding the use of mental health services (Kessler, Mickelson, & Williams, 1999; McGuire & Miranda, 2008; Wells, Klap, Koike, & Sherbourne, 2001), further research is warranted.
In a current study by Hunt et al., (2013), the authors compared beliefs about mental illness and treatment preferences among adult African Americans, Hispanics, Asian Americans, Native Americans, and Whites; they found no significant difference among group beliefs but highlighted that “differences in illness beliefs and treatment preferences did not fully explain the large, persistent racial disparities in mental health care” (p. 188). The authors conclude further research is warranted to search for the “malleable barriers” that explain better the “large, persistent racial disparities” in our current healthcare system, and seek to create appropriate interventions to address these inequalities (Hunt et al., 2013, p. 195).

**Racism**

The literature on perceived racism and mental health among African Americans suggests a relationship between the effects of perceived racism and negative psychological and physiological outcomes (Pieterse, Todd, Neville, & Carter, 2012; Smedley, Stith, & Nelson, 2003; Williams, Jackson, & Anderson, 1997). For the majority of marginal and oppressed populations, disparities and unjust treatment can be part of their daily existence (Pieterse, Todd, Neville, & Carter, 2012). For this reason, perceived racism could happen at the interpersonal, institutional, and cultural level, creating distress in an individual and/or group of people. Being that African Americans have reported more incidences of racism than any other racial/ethnic minority group, it is believed that racism is a source for health disparities in this population (Pieterse, Todd, Neville, & Carter, 2012). For example, African Americans have higher rates of hypertension, which can be linked to stress and depression (Heard, Whitfield, Edwards, Bruce, & Beech, 2011).
Chronic Community violence

Research indicates that low-income African Americans living in urban settings are at a greater risk of experiencing traumatic events and having symptoms of PTSD (Alim et al., 2006; Breslau et al., 1998; Liebschutz, Saitz, Brower, Lloyd-Travaglini, & Samet, 2007). In urban settings common traumatic experiences tend to be assaultive traumas such as sexual assault, friends or family member murdered, and can lead to greater risk of symptoms of PTSD (Breslau et al., 1998). African Americans were found to have a 65% rate of lifetime trauma exposure and a 33% rate of PTSD (Alim et al., 2006). But PTSD is all too often under-diagnosed and untreated in racial and ethnic minority populations (Davis, Ressler, Schwartz, Stephens, & Bradley, 2008; Magruder et al., 2005; Swartz, Bradley, Sexton, Sherry, & Ressler, 2005). The research suggests African Americans living in urban environments and experiencing low SES have a higher likelihood of experiencing assaultive traumas and have symptoms of PTSD but are under-diagnosed.

The Hill and Community Trauma

A recent qualitative dissertation by Katy Sampson (2009) highlights some of these “malleable barriers” suggested by Hunt et al. (2013), but the question needs further investigation. Sampson explored the contextual nature of community care from a community psychology perspective in the Hill. Her study highlights the influence of systemic issues such as economics, place, power, and discrimination can have on the individual’s (client) subjective meaning (i.e., identity), as well as ecological factors. An unanticipated theme identified in her study was the prevalence of the term “community trauma,” which was used by all the clinicians whom she interviewed for her study. “Staff
interpreted their observations of suffering, stories of victimization and violence, family disruption and fragmentation, and spiritual struggles as evidence for the existence of what they called ‘community trauma or community PTSD’” (Sampson, p. 159). There are a number of empirical studies (Breslau, 2004; Herman, 1992/1997; Jones, 2007; Levers, 2012; McFarlane, 1987) that focus on the impact of traumatic events experienced by a community, but the context for which “community trauma” is used is differently from the way the staff members used the term. In the literature, community trauma is associated with chronic violence, major natural disaster, genocide, and war (Levers and Buck, 2012). There is a gap in the literature addressing the idea of “community trauma” as described by the staff interviewed in Sampson’s study. She explains the community trauma to which staff members are alluding is influenced by historical events such as slavery, the demolition of family homes and the community’s business district in the name of Urban Renewal in the 1950, as well as institutional racism. Sampson states that “community trauma,” as defined by the staff members, was the primary context for which clinicians conceptualized clients. However, the study only includes interviews from clinical staff, as opposed to clients or key stakeholders from the community. Therefore, the definition is solely from a community psychology perspective. A more heterogeneous population sample, which would consist of varying opinions about community trauma in the Hill, is needed in order to give more insight into the variables associated with community trauma, social justice implications, and possible holistic/intergraded community-based services appropriate for the community.
Statement of The Problem

Disparities in mental health care between African Americans and Caucasians have increased significantly since the 1990s, and social determinates such as poverty, access to resources, education, institutionalization, and housing status can influence these disparities (Primm, et al., 2010). Potential barriers to treatment have been identified to exist on the individual, institutional, and cultural level in ethnic/racial minority populations. Although research is inconsistent in regards to attitudes and/or beliefs towards barriers to treatment, empirical research shows significant racial inequality in use of mental health services (Kessler, Mickelson, & Williams, 1999; McGuire & Miranda, 2008; Wells, Klap, Koike, & Sherbourne, 2001). Hunt et al., (2013) posit that differences in beliefs and treatment preferences do not fully explain racial disparities that do exist in the mental health system. The authors conclude that further research is needed to search for the “malleable barriers,” research that better explains the pervasive racial disparities in the current healthcare system. Further examination of these malleable barriers could produce better treatment delivery and reduce access to barriers to quality treatment.

Snowden and Yamada (2005) state that further research with representative community samples are needed to “observe the help-seeking processes at a higher level of detail.” In addition, Primm et al., (2010) call for more community-based research focusing on social determinants, community needs, and well-being.

In addition, African Americans have reported more incidences of racism than any other ethnic/minority group in the U.S (Pieterse, Todd, Neville, & Carter, 2012). The literature suggests a relationship between “perceived” racism and negative physical and psychological well-being (Chao, Longo, Wang, Dasgupta, & Fear, 2014; Heard,
The empirical literature uses the term “perceived racism,” but the term “perceived” has the potential of placing the experience of racism solely on the individual interpretation. The possible unintended or intended consequence of the term “perceived” in front of the word racism, implies that racism may only exist if an individual becomes consciously aware of it. The use of the term “perceived” could have the effect of lessening the lived experience of racism for African Americans in the U.S. Noting that the literature uses the term “perceived racism,” I will use quotation marks when referencing the literature, but I will use only the term “racism” when referencing my own data findings. The Hill community is predominately African American, suggesting that racism on the individual, institutional, and cultural level could be a major contributing variable in mental health disparities for this community. Additional research is necessary to more fully explain the lived experience of racism and discrimination of key stakeholders as a possible barrier to seeking treatment.

Finally, the literature indicates that low-income African Americans living in urban settings are at a greater risk of experiencing traumatic events and have symptoms of PTSD (Alim et al., 2006; Breslau et al., 1998; Liebschutz et al., 2007;). Alim, Graves et al., in their study of 617 African Americans, found a 65% rate of lifetime trauma exposure and a 33% rate of PTSD. But the research also indicates that all too often, PTSD is under-diagnosed and untreated (Magruder et al., 2005; Swartz et al., 2005). These studies indicate a higher likelihood that low socioeconomic African Americans living in urban environments will experience assaultive traumas and have symptoms of PTSD but remain under-diagnosed, possibly because of barriers to treatment.
Purpose and Objective of the Study

The Adverse Childhood Experiences (ACE) study (1995-1997) is the largest study to date, with more than 17,000 participants, which has linked health risk behavior and disease in adulthood to exposure to emotional, physical, or sexual abuse, and household dysfunction during childhood (Felitti, et al., 1998). The study found a strong graded relationship to the amount of exposure to abuse or household dysfunction and multiple risk factors associated with some of the leading causes of death in adults. In addition to adverse childhood experiences as risk factors for adult well-being, potential barriers to treatment have been identified to exist on the individual, institutional, and cultural level in ethnic/racial minority populations. Although research is inconsistent in regard to attitudes and/or beliefs toward barriers to treatment, empirical research shows significant racial inequality in the use of mental health services (Kessler et al, 2005; McGuire et al, 2008; Wells et al, 2001). Snowden and Yamada (2005) state that further research with representative community samples is needed to “observe the help-seeking processes at a higher level of detail.” In addition, Primm et al., (2010) call for more community-based research focusing on social determinants, community needs, and well-being.

Violence in our country is all too common; this is especially true in urban areas where low-income populations frequently live. Research indicates that low-income residents living in urban settings are at a greater risk of experiencing traumatic events and having symptoms of PTSD (Alim et al., 2006; Breslau et al., 1998; Liebschutz et al., 2007). Also, the research indicates that all too often PTSD is under-diagnosed and untreated (Magruder et al., 2005; Swartz et al., 2005).
The primary purposes of this study are twofold: first, to work with key stakeholders in the Hill District, through existing programming at FOCUS Pittsburgh, in identifying and defining social determinants that influence mental health disparities and in exploring the lived experiences of key stakeholders who are concerned with planning and implementing emergent community-based services; second, to identify potential pathways or mechanisms for designing culturally appropriate mental health services for residents in a low-income urban community affected by community trauma. This study analyzed pertinent information that helped inform the planning of emergent community-based services. It added depth, provided resource knowledge, and helped to guide the project in a meaningful ways. The pertinent information from the analysis helped the key stakeholders understand more fully how community trauma in an urban context affects social and individual recovery, as well as identified the protective and risk factors involved in the help-seeking processes. Finally, this study responds to a recent directive from President Obama, with SAMHSA’s (Substance Abuse and Mental Health Association) endorsement, to start a national conversation about mental health in order to reduce shame and secrecy associated with mental illness (SAMHSA, 2013).

**Research Questions**

This study sought to illuminate and parse out the lived experiences of Hill District key stakeholders experience of community trauma and potential barriers to healing and recovery. The guiding question for the project is, “How does community trauma affect social as well as individual recovery and the process of recovery in the community context?” There are four subsidiary questions: (1) What is the lived experience of key stakeholders in an urban setting towards his/her lived time, lived space, lived body, and
lived relation (van Manen, 1990). (2) What are the protective and risk factors involved in the help-seeking processes? (3) What factors may contribute to community and individual agency? (4) What potential mechanisms can be identified that can assist in community trauma abatement or prevention programming?

**Assumptions**

There is something unique and not-so-unique about the history and present-day experience of African Americans living in the Hill. Unique to a particular time and place is the fact that individuals in the community, out of resourcefulness and necessity, turned the Hill into one of the most prominent and vibrant African American neighborhoods in the U.S. (e.g., “Wiley Avenue Days”). The Hill produced its own doctors, lawyers, schools, emergency services; it was a major contributor to the arts, baseball, politics, and prominent businesses. The Hill, unfortunately, is not unique in suffering from the effects of racism, discrimination, and segregation that has afflicted American history and continues today. African Americans disproportionately experience low SES and assaultive trauma and therefore mental distress. As the director of FOCUS shared with me, trauma is “a shared experience of suffering that characterizes the personal experience of many in the community…trauma is the foundation upon which the community worldview is laid” (P. Abernathy, personal correspondence, July 2, 2013). I hypothesize that there is a link (i.e., time and place) between the “worldview” articulated by the director of FOCUS, and disparities in accessing mental health treatment.

**Theoretical and Conceptual Framework**

To guide and ground my qualitative study I used the following theoretical frameworks to make more explicit the lived experience of key stakeholders planning
emergent community-based services to address “community trauma.” The theoretical approaches include: (a) van Manen’s *Lifeworld Existentials* (1990), (b) Bronfenbrenner’s (1979, 2006) Bioecological Model of Human Development, (c) Historical Trauma Theory (e.g., Sotero, 2006), (d) Posttraumatic Slave Syndrome (DeGruy, 2005), (e) Social Cognitive Theory (Bandura, 2001), (f) theories of motivation (Maslow, 1971; Ryan & Decci, 2000), and (g) Narrative Construction Meaning-Making Identity (e.g., Singer, 2004).

**van Manen’s *Lifeworld Existentials***

van Manen’s (1990) *Lifeworld Existentials* provides a sensitive methodological approach to the understanding of community trauma as well as the attitudes and beliefs associated with mental health care. The four existential themes that guide the inquiry are “lived space, lived body, lived time, and lived other” (van Manen, 1990). Lived space is not just the physical space in which an individual resides, but it is also how a person experiences his or her being in the day-to-day activities of his or her life. Lived body is an individual’s understanding of his or her physical presence in the world. Lived time is an individual’s biography. It is the past influencing the present and the future, as well as the present or the future influencing the past. Lived other is an individual’s interaction with others or relationships that share space in his or her life. These four reflection guides will be used to capture an individual’s meaning behind the existential crisis caused by a trauma and the factors associated with an individual’s Lifeworld Existentials experience of disparities in mental health.
**Bronfenbrenner’s Bioecological Model for Human Development**

Trauma research has increasingly shown the importance of understanding and conceptualizing trauma from an ecological framework (Garbarino, Kosteiny, & Dubrow, 1991; Levers, 2012; Lynch & Cicchetti, 1998; Overstreeet, 2003). An ecological perspective posits that an individual is “nested” in multiple levels with varying degrees of proximity to the individual (Lynch & Cicchetti, 1998). The basic premise of an ecological framework is that children and adults function within multiple contexts, ecologies or environments that influence each other and development over the life span (Bronfenbrenner & Morris, 2006; Lynch & Cicchetti, 1998). These ecologies or environments vary in proximity to the individual and influence the development of the individual in varying degrees. For example, cultural beliefs and values would be considered a macrosystem and the most distal ecology or furthest from individual. The microsystem includes ecologies most proximal or close to the individual, such as family, peers, and school environments. Between the macrosystem and microsystem are additional systems, as well as a time dimension. Important to Bronfenbrenner’s Model are the “proximal processes,” that is, consistent, prolonged, and reciprocal interactions between the individual and his or her immediate environment. These proximal processes are the essential building blocks of development, contributing to an individual’s motivation, skill, knowledge, and ability to perform daily tasks and to build self-efficacy and resilience.

When applied to community trauma, the Model gives a framework to analyze the interior and exterior influences on the individual and how he or she processes and constructs meaning from the traumatic experience. Also, the Model places an emphasis
on the relationship between heredity and environment making it compatible with historical trauma theory. This Model takes into account the objective and subjective elements of an individual’s development. Viewing only one (i.e., objective) would be insufficient in understanding the development and narrative construction of an individual’s worldview. In addition, using an ecological framework allows the researcher to identify protective and risk factors that can influence resiliency and well-being or maladaptation (Bronfenbrenner & Morris, 2006; Levers, 2013).

**Historical Trauma Theory**

Historical trauma theory provides a macro-level observation of the life experiences of a population exposed to trauma at a certain point in time relates to an unexposed population (Heart & DeBruyn, 1998). Historical trauma theory posits that psychological and emotional scars from the trauma of slavery are passed down through succeeding generations through physiological, environmental and social pathways resulting in an intergenerational cycle of trauma responses (Sotero, 2006, p. 95). Historical trauma theory offers a path to contextualize current psychological and emotional distress articulated by the term community trauma. Historical trauma theory will illuminate or bring to the front the possible underlying historical factors contributing to mental distress and mental health disparities in racial/ethnic minority populations.

**Post Traumatic Slave Syndrome**

In addition to historical trauma theory, Joy DeGruy’s (2005) book, *Posttraumatic Slave Syndrome: America’s legacy of enduring injury and healing* provides a historical context for understanding the negative perceptions, images, and behaviors many African Americans experience as result of slavery. She proposes the concept of Post Traumatic
Slave Syndrome (PTSS) to conceptualize the current lived experience of many African Americans as related to trans-generational adaptations linked to past traumas of slavery and on-going oppression (p. 13). She identifies three categories; (a) vacant esteem, (b) ever-present anger, and (c) racist socialization. For many in the Hill District, the residual effect of transgenerational trauma associated with slavery and DeGruy’s conceptualization of PTSS added another dimension and insight into the lived experience of community trauma in this community.

**Narrative Construction Meaning-Making Identity**

Singer (2004) outlines the development of narrative identity and current research trends that study narrative meaning making identity. The research of narrative identity views each individual as a unique social being in the world and seeks further understanding of how an individual searches for meaning and what influences meaning making, such as culture, life stage, gender, and ethnicity in a narrative construction (Singer, 2004). Singer identifies four common principals in the research: (a) The centrality of narrative to identity formation; (b) the role of cognitive-affective processes; (c) an emphasis on lifespan developmental approach; (d) sociocultural factors. According to the literature, how an individual constructs his/her narrative is paramount to identity formation. Meaning, an individual’s developmental stage and sociocultural context contributes to the construction of meaning making identity. In other words, an individual makes meaning through his or her narrative construction, thus influencing the individual’s worldview. The narrative construction meaning making identity formation adds another level of understanding to Bronfenbrenner’s Bioecological Model (2006),
historical trauma theory (Sotero, 2006) and PTSS (DeGruy, 2005), and companion to van Manen’s *Lifeworld Existentials* (1990).

**Theories of Motivation**

The Bioecological Model (Bronfenbrenner, 2006) suggests that individuals interact within their environments bidirectionally. Within these environments exists interactions between the individual and primary care givers, others in the community, objects, and symbols. These interactions, between the individual and the environment over time, can have a negative or positive influence on the development of the individual. Similar, theories of motivation theorize about what an individual needs to grow, mature, and be motivated to reach his or her full potential. Two such theories are self-determination theory (Ryan & Deci, 2000), and Maslow’s Hierarchy of Needs Model (1971). Self-determination theory suggests that the social context must provide the resources for three innate psychological needs to be met for an individual to grow, be motivated, and be integrated. The three psychological needs are competence, relatedness, and autonomy. Likewise Maslow’s Hierarchy of Needs Model describes the basic building blocks or needs for an individual to actualize their potential. The Model is illustrated as a five-tier pyramid. The five tiers of the pyramid include, in ascending order: (1) the basic physiological needs to live, (2) safety and security needs, (3) love and belonging, (4) esteem, and (5) self-actualization. The literature consistently shows that in many low SES urban communities many of these basic needs or resources represented in these two Models are not readily available in the community.
Social Cognitive Theory

In addition to theories of motivation, social cognitive theory suggests that individuals are active participants or agents in their environment, where each individual’s thoughts are not “disembodied, immaterial entities that exist apart from neural events” (Bandura, 2001, p. 4). Human agency has four core features: intentionality, forethought, self-reactiveness, and self-reflectiveness. One important aspect of self-reflectiveness that is directly related to my research is the idea of “Perceived self-efficacy.” “Perceived self-efficacy occupies a pivotal role in the causal structure of social cognitive theory because efficacy beliefs affect adaptation and change not only in their own right, but through their impact on the other determinants” (Bandura, 2001, p. 10). Efficacy affects how an individual feels, thinks, behaves, and is motivated. Efficacy is not something innate in a person, but instead, is learned developmentally. Like the two theories of motivation described above, human agency can develop when healthy proximal processes are present developmentally. Environmental factors (i.e., school, family, peers) play a crucial role in whether or not a person develops a high or low self-efficacy. Social cognitive theory also takes into account that in some spheres of functioning, individuals do not have control over their social conditions and need “proxy” agency.

Significance of the Study

The importance of this study is a matter of social justice. In 2010, Counselors for Social Justice (CSJ), a subgroup of ACA, created a code of ethics as an expansion of the ACA Code of Ethics, but from a social justice orientation. The CSJ Code of Ethics defines social justice as the following:
Social justice requires that CSJ professionals recognize historical, social, and political inequities in the treatment of people from non-dominant groups and work to remove such inequities at the individual, institutional and societal levels. Such efforts require social justice minded counselors to be ever vigilant of the various injustices and different types of oppression that contribute to people’s mental health problems as these professionals work to create an equitable and fair social system (Ibrahim, Dinsmore, Estrada, & D’Andrea, 2011, p. 2)

This study was conducted and written from a social justice perspective (i.e., participant action research). The idea that health disparities exist at all, points directly to injustices and deficiencies in our current behavioral healthcare system. The significance of this study is not solely to add research to the current literature, but more importantly begin to change unjust barriers and systems to behavioral health treatment. I hypothesize that the proposed change to the system in my study occurs by developing community-driven behavior health initiatives that not only focus on individual well-being but also community well-being. This study seeks to describe a new model for addressing the needs of a racial/ethnic trauma-informed community. Adding to the current trend of “integrated care” and “trauma-informed approaches,” this study seeks to add community development as part of an integrated and trauma-informed approach. This approach integrates individual and community well-being by suggesting a trauma-informed community development strategy. This strategy attempts to address the injustices related to social determinants, stigma, and reduce adverse experiences in a trauma-informed community.
Definition of the Terms

**Health Disparity** - A type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability (U.S. Department of Health and Human Services, 2009).

**Mental Health** - is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community (SAMHSA, 2013).

**Mental Illness** - is defined as “collectively all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.” Under these definitions, substance use might be classified as either a mental health problem or a mental illness, depending on its intensity, duration, and effects (SAMHSA, 2013).

**Mental Health Treatment** - is the provision of specific intervention techniques by a professional for conditions identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). These interventions should have proven effectiveness, the ability to produce measurable changes in behaviors and symptoms, and
should be person and family centered and culturally and linguistically appropriate (SAMHSA, 2013).

**Post Traumatic Slave Syndrome** - A condition that exists when a population has experienced multigenerational trauma resulting from centuries of slavery and continue to experience oppression and institutionalized racism today. Added to this condition is a belief (real or imagined) that the benefits of the society in which they live are not accessible to them. This, then, is Post Traumatic Slave Syndrome:

- Multigenerational trauma together with continued oppression and
- Absence of opportunity to access the benefits available in the society

leads to…

**Post Traumatic Slave Syndrome.** \( M + A = P \) (DeGruy, p. 121).

**Racism** - Racism as the transformation of racial prejudice into individual racism through the use of power directed against racial group(s) and their members, who are defined as inferior by individuals, institutional members and leaders, and which is reflected in policy and procedures with the intentional and unintentional support and participation of the entire race and dominant culture (Jones and Carter, 1996).

**Social Determinants of Health** - The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world (CSDH, 2008).
**Stigma** - refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma is widespread in the United States and other Western nations. Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders — especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care. Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment. (New Freedom Commission on Mental Health. Achieving the promise: transforming mental healthcare in America. Final report. US Department of Health and Human Services; 2003).

**Trauma** - Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. (SAMHSA, 2012, Part one: Defining trauma, para. 1)

**Trauma-informed community** - A shared experience of suffering that characterizes the personal experiences of many in the community. Chronic unemployment, crime, drugs, homelessness, hunger, abuse, poverty, and most profoundly brokenness and radical isolation have all created a culture informed first and foremost by trauma. For this reason, trauma is the foundation upon which the community worldview is laid (P. Abernathy, personal communication, July 2, 2013).
**Well-being** - Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (CSDH, 2008).

**Organization of the Dissertation**

This study is organized into five chapters. The literature review is presented in Chapter 2. I present a theoretical framework to guide and to make more explicit the lived experience of the key stakeholders who have planned emergent community-based services to address the idea of “community trauma.” The selected theoretical approaches include: (a) van Manen’s (1990) *Lifeworld Existentials*, (b) Bronfenbrenner’s (1979, 2006) Bioecological Model of Human Development, (c) Historical Trauma Theory (e.g., Sotero, 2006), (d) Posttraumatic Slave Syndrome (DeGruy, 2005), (e) Social Cognitive Theory (Bandura, 2001), (f) Self-Determination Theory (Ryan & Decci, 2000), and (g) Narrative Construction Meaning-Making Identity (e.g., Singer, 2004). Next, I give a brief history of the development of psychological trauma, and review the diverse definitions and constructs of individual psychological trauma and “community trauma” from the literature. I detail the literature on mental health disparities in ethnic/racial minority groups, specifically stigma, racism, and social determinants and gaps in the literature. Further, I describe the relevant literature associated with the effects of chronic community violence. Finally, I discuss the need for applied community-based research.

Chapter 3 describes the qualitative methodology I used for this study. I present the conceptual framework, research design, participants and sampling, and methods and procedures. Finally, I describe my instruments, data collection, and recording procedures.
In Chapter 4, I present my exploratory findings that highlight the protective and risk factors influencing community trauma and the help-seeking processes. In addition, I use van Manen’s (1990) *Lifeworld Existentials* to generate themes from the focus groups to make explicit the key stakeholders’ lived experience of community trauma and planning emergent community-based services. Finally, I describe the applied practices of the results from this study.

Chapter 5 provides an overview of my research project. A discussion of my major finding will be presented using van Manen’s (1990) *lifeworld existentials* with consideration to ecological factors and operationalize the term trauma-informed community. Next, I describe the implications and how my research project has been applied to a community-driven behavioral approach resulting in a trauma-informed community development strategy. The section concludes with a description of the limitations of my study, future research considerations, contribution to the professional literature, and summary.
Chapter 2: Literature Review

Introduction

In 1963 President John F. Kennedy delivered a speech to Congress on mental health and illness. Kennedy’s speech signaled the beginning of the deinstitutionalization of state hospitals and sought to create nationwide community mental health centers (Gronfein, 1985). President Kennedy believed that federal dollars would be better spent funding community treatment facilities than state hospitals. His speech implies that community facilities allow individuals to stay in their homes and to receive better treatment. He also believed that community treatment facilities would also reduce the hardships on the individual and the family. On October 31, 1963, President Kennedy signed into the law the Community Mental Health Act. While an exhaustive history of community health care centers is beyond the scope of this project, it is important to note the shift in care of individuals suffering from mental health issues in the United States. Fifty years have passed since Kennedy’s speech, and much progress has been made in quality and access to mental healthcare. Although progress has been made for some, less progress has been made for racial/ethnic minority populations.

The literature empirically validates that racial/ethnic disparities exist in the current mental health system (Snowden, 2001; Snowden & Yamada, 2005) and highlights the complexity involved in researching racial/ethnic disparities. However, there is less consensus regarding the primary influences that create barriers to treatment (e.g., stigma). In addition, the literature suggests that further community-based research needs to occur to better inform intervention strategies for racial/ethnic minority groups.
My study focuses on the lived experience of key stakeholders in relation to community trauma from an ecological perspective. To contextualize my findings within the literature, I organize this chapter into seven sections. First, I present a theoretical framework to guide and to make more explicit the lived experience of key stakeholders planning emergent community-based services to address “community trauma.” The selected theoretical approaches I include are: (a) Van Manen’s *Lifeworld Existentials* (1990), (b) Bronfenbrenner’s (1979, 2006) Bioecological Model of Human Development, (c) Historical Trauma Theory (e.g., Sotero, 2006), (d) Posttraumatic Slave Syndrome (DeGruy, 2005), (e) Social Cognitive Theory (Bandura, 2001), (f) theories of motivation (e.g., Maslow, 1971; Ryan & Decci, 2000), and (g) Narrative Construction Meaning-Making Identity (e.g., Singer, 2004). Second, I give a brief history of the development of psychological trauma. Third, I review the diverse definitions and constructs of individual psychological trauma and “community trauma” from the literature. Fourth, I describe SAMHSA’s (2014) trauma-informed approach. Fifth, I detail the literature on mental health disparities in ethnic/racial minority groups, specifically stigma, racism, and social determinants. Sixth, I describe the relevant literature associated with the effects of chronic community violence. Finally, I discuss the need for applied community-based research.

**Theoretical Framework**

**van Manen’s *Lifeworld Existentials***

How does a researcher attempt to make explicit the meaning of the lived experience? Max van Manen (1990) asks this very question and offers a hermeneutic phenomenological framework for this type of inquiry. Phenomenological research
attempts to get at the “essence” of a phenomenon by bringing the phenomenon into the light, describing ecologies, and revealing the “internal meaning structures” of the lived experience. van Manen states that phenomenological research is “explicit in that it attempts to articulate, through the content and form of text, the structures of meaning embedded in lived experience” (p. 11). For example, when I look at a Vincent Van Gogh painting, I am immediately drawn into the painting. The encounter with Van Gogh, the artist, starts with me (i.e., the researcher) through the painting. The encounter with the painting sparks my imagination and I begin to actively attempt to make meaning from the form (i.e., colors, brush strokes) and text (i.e., composition and subject). In my attempt to make meaning of the painting, I draw from my research about the artist and allow the past to inform my present interpretation. I imagine Van Gogh as a tortured soul in many respects, who was obsessed with mastering his craft. I picture him painting a landscape en plein air, transforming a blank canvas into a tool to communicate his encounter with nature, an idea or concept, an emotion, theme, time of day, or an articulation of the self. The role of the onlooker or phenomenological researcher is to attempt to make “explicit” that which lies beneath (i.e., essence) the layers of vibrant colors and exaggerated brush strokes to a deeper understanding of Van Gogh’s lived experience of creating the painting.

To attempt to make explicit the very subjective nature of key stakeholders’ experiences of community trauma, a sensitive, phenomenologically oriented theoretical framework is needed. van Manen’s (1990) Lifeworld Existentials gives the researcher a framework for researching sensitive topics. The four Lifeworld Existentials are lived
space, lived body, lived time, and lived other. The following sections expand on the four

*Lifeworld Existentials*.

**Lived Space.** Lived space is not only the physical space in which a person resides, but it also is how an individual experiences his or her being in the day-to-day activities of life. van Manen contends that trying to articulate lived space is very difficult, because the lived experience of space is “largely pre-verbal” (p. 102). Lived space is largely pre-reflective, in that most individuals do not frequently reflect on daily interactions with their environment. As a potential consequence of the pre-verbal nature of lived space, an emotion is often first experienced, which may reflect a sense of self in the space. For example, if I am driving through a dilapidated neighborhood, I may feel unsafe or afraid. My emotional response of feeling unsafe and afraid reflects that the environment does not convey a sense of safety or security as I experience it. Lived space is an inquiry into an individual’s lived experience of his or her home, church, neighborhood, community center, or school, and how it can affect our emotions, identity, and personality characteristics.

**Lived Body.** Lived body is an individual’s understanding of his or her physical presence in the world. Phenomenologically, an individual is a being-in-the-world (e.g., Heidegger, 1927) in that an individual first encounters the other through the (or his or her) body. For example, a fair skinned girl grows with blotches all over her body and she does everything to cover up the spots. She hates her body because of the blotches. One day later in life she meets someone who “loves” the blotches and finds her very attractive. Soon the young woman begins to see her blotches in a new way and the shame associated with the blotches is transformed. She begins to appreciate her body, including
her blotches. “In our physical or bodily presence we both reveal something about ourselves and we always conceal something at the same time—not necessarily consciously or deliberately, but rather in spite of ourselves” (van Manen, p. 103). Lived body guides the researcher to a deeper understanding of the key stakeholders’ bodily experience of the world around them.

**Lived Time.** Lived time is an individual’s biography. It is the past influencing the present and the future, as well as the present or future influencing the past. For example, my wife asks me to go to the store to rent a DVD from the Red Box. She gives me no direction about which DVD to rent. My past experience of watching movies with my wife sets the conditions for probable decisions I will make in choosing a movie. My present action of renting a movie at the store originates from a future context, such as my wife asking me to go to pick-up a DVD. The past and future are not two distinct realms, but instead are embodied in the present. Trauma can leave a lasting effect on an individual that manifests in memories and can influence an individual’s self-concept. “Whatever I have encountered in my past now sticks to me as memories or as (near) forgotten experiences that somehow leave their traces on my being—the way I carry myself (hopeful or confident, defeated or worn-out)” (p. 104). Lived time guides the researcher to a fuller analysis of the key stakeholders’ biography, including the idea of transgenerational trauma.

**Lived Other.** Lived other is an individual’s interactions with others or relationships that share space in his or her life. Lived other brings to the forefront interpersonal themes and projections we make about others in our interactions with them. For example, if I meet a person for the first time with a handshake, the form and context
of the handshake can take on a lot of meaning. Is the handshake firm, gentle, aggressive, or limp, and is the hand soft or rough. This common greeting has the potential to generate meaning about each other’s being-in-the-world. In addition, van Manen contends that existentially, human beings seek out relationships with others to find a sense of purpose or meaningfulness, community, or in the religious context the “absolute other, God” (p. 105). Lived other guides the researcher to uncover and make explicit the key stakeholders’ lived experience of community trauma.

**Bioecological Model of Human Development**

Uri Bronfenbrenner (1979, 2006) developed the Bioecological Model of Human Development to more fully understand the complex interplay multiple-systems or environments can have on a child’s development, as well as individuals throughout the lifespan. A child or an adult does not live in a vacuum. Rather, the environment he or she resides in directly influences the development of the individual. The Model not only posits the influence of the environment on the development of the individual, but also on groups or community. The Bioecological Model defines development as the “phenomenon of continuity and change in the biopsychological characteristics of human beings, both as individuals and as groups” (Bronfenbrenner & Morris, 2006, p. 793). It includes four properties: process, person, context, and time. Human development, especially in early life phases, occurs through processes that gradually increase in complexity and are reciprocal interactions between the individual and persons, objects, and symbols in the individual’s immediate external environment. For these processes to be effective, the interactions between the individual and his or her immediate environment must happen on a consistent basis and over a prolonged period of time.
Therefore, “process” is the core construct of the model. More specifically, “proximal processes” represent the consistent, prolonged, and reciprocal interactions between the individual and his or her immediate environment. Examples of proximal processes include; “feeding or comforting a baby, playing with a young child, child-child activities, group or solitary play, reading, learning new skills, athletic activities, problem solving, caring for others in distress, making plans, performing complex tasks, and acquiring new knowledge and know-how” (Bronfenbrenner & Morris, 2006, p. 797). These proximal processes are the essential building blocks of development, contributing to an individual’s motivation, skill, knowledge, and ability to perform in the above activities.

In addition, three types of personal characteristics have been identified as most influential in shaping these essential building blocks of development over the lifespan. The three personal characteristics are: (a) temperament or disposition; (b) bioecological resources, which include an individual’s ability, experience, knowledge, and skills, and; (c) demand, in which an individual invites or discourages reactions from the social environment, that can promote or disrupt the operation of the proximal processes (Bronfenbrenner & Morris, 2006). These personal characteristics can directly affect the path and strength of the proximal processes throughout the life span. For example, if a child’s primary caregiver’s interactions (i.e., proximal processes) foster knowledge and skills, problem solving, healthy attachments, an evolving complex emotional vocabulary, and an immediate environment that promotes a feeling of stability and safety, then he or she can be a buffer against negative psychological effects of traumatic experiences (Lynch & Cicchetti, 1998; Overstreet, 2003; van der Kolk, 2005). The opposite can be true when a child’s proximal processes are inhibited or stunted. If the immediate
environment is chaotic and unstable, this can adversely affect his or her competence over the lifespan as well as personal characteristics. In essence, the model posits that characteristics of the individual “function both as an indirect producer and product of the environment” (Bronfenbrenner & Morris, 2006, p. 798). In other words, an individual’s interactions with his or her environment is not unidirectional, but rather bidirectional or multidirectional in nature.

**Figure 1 Bronfenbrenner’s Bioecological Model of Human Development**
The next defining property of the Bioecological model is “context.” The model illustrates how an individual is “nested” in proximal (i.e., environments in closest proximity to the individual) and distal systems (i.e., environments furthest away from the individual) influencing development over time. The individual or the ontogenic ecology is at the center of multiple extending ecologies or environments. From the individual’s immediate environment, the Model illustrates concentric circles showing the influences of other more distance systems, such as attitudes and ideologies of culture can have on human development. These systems or ecologies are classified as the following: microsystem, mesosystem, exosystem, macrosystem, and chronosystem (see figure 1). The microsystem is the immediate setting in which an individual lives. It represents the individual’s most direct interactions with family, peers, schools, and neighbors. These proximal relationships are individuals who interact with the individual often and over extended periods of time. The individual is also an active participant in the construction of this system. The mesosystem contains the process of two or more settings interacting in the microsystems; it is the effect of the relationship, connections, or experiences the individual has within the Microsystems. For example, the mesosystem shows the relationship and interactions between a child’s home environment and school environment. The exosystem are the experiences with the wider community and neighborhood that influence the individual indirectly. An example of this indirect influence is chronic community violence. The macrosystem is the accumulation of the characteristics of all the systems in a given culture or subculture. Included in the macrosystem are beliefs, material resources, bodies of knowledge, customs, life-styles,
opportunity structures, and hazards. The macrosystem is the societal influences on microsystem.

The final system parameter Bronfenbrenner includes is the chronosystem, which puts the model into a third dimension of time. The chronosystem is not only chronological age, but also the experience of time after an experience. The chronosystem has three consecutive levels: (a) microtime, (b) mesotime, and (c) macrot ime. Microtime signifies whether the proximal processes occur consistently or not and the mesotime indicates the consistency over longer periods of time, such as days and weeks. Macrot ime investigates potential changing social norms and events in the larger society. This can take place within generations or across generations. The Bioecological model puts an emphasis on the relationship between heredity and environment making it compatible with historical trauma theory (Atkinson, Nelson, & Atkinson, 2010; Sotero, 2006) and Posttraumatic Slave Syndrome (DeGruy, 2005). Further, this model takes into account the objective and subjective elements of an individual’s development. Bronfenbrenner states, “It is therefore important to understand the nature of each of these two dynamic forces, beginning on the phenomenological or experiential side” (2006, p. 797). Viewing only one (i.e., objective) would be insufficient in understanding the development and narrative construction of an individual’s worldview. Similarly, van Manen’s (1990) life word existentials helps to capture and make explicit these two dynamic forces.

**Historical Trauma Theory**

Historical trauma theory may give insight into the idea of “community trauma” as well as potential barriers to treatment. Historical trauma theory tries to understand “how” and “why” certain populations have a greater likelihood of disease than others.
theory was first conceptualized in the 1960s based on studies of persistent trauma related to stress among Holocaust survivors and their families. The theory provides a macro-level observation of how the life experiences of a population exposed to trauma at a certain point in time relates to an unexposed future generation (Heart & DeBruyn, 1998; Sotero, 2006). Sotero states, “a key feature of historical trauma theory is that the psychological and emotional consequences of the trauma experience are transmitted to subsequent generations through physiological, environmental and social [ ecological] pathways resulting in an intergenerational cycle of trauma response” (p. 95). The Hill community is predominantly African American, and historically this population has experienced collective trauma(s), such as slavery, Jim Crow Laws, and institutional racism. Historical trauma theory offers a path to contextualize current psychological and emotional distress as articulated by the term “community trauma.” In addition, current research has begun to link historical or transgenerational trauma with racial and ethnic health disparities (Atkinson, Nelson, & Atkinson, 2010; Sotero, 2006; William, Neighbors, & Jackson, 2003).

Sotero’s (2006) model begins with the subjugation of a population by a dominant group. Four elements must be present as part of the suppression: “(a) overwhelming physical and psychological violence, (b) segregation and/or displacement, (c) economic deprivation, and (d) cultural dispossession” (p. 99). From the primary generation that experienced the subjugation, future generations can be affected by the original trauma through various factors. These factors are bi-products of extreme trauma experienced by the primary generation. Sotero states, “Extreme trauma may lead to subsequent impairments in the capacity for parenting. Physical and emotional trauma can impair
genetic function and expression, which may in turn affect offspring genetically, through in-utero biological adaptations, or environmentally” (p.99). In addition, Sotero argues that future generations can experience vicarious traumatization through storytelling and oral traditions of the population. Sotero claims that historical trauma theory “creates an emotional and psychological release from blame and guilt about health status, empowers individuals and communities to address the root causes of poor health and allows for capacity building unique to culture, community and social structure” (p. 102). Historical trauma theory can shed light on the possible underlying factors contributing to mental distress and mental health disparities in racial/ethnic minority populations.

**Post Traumatic Slave Syndrome**

In addition to historical trauma theory, Joy DeGruy’s (2005) concept of “Posttraumatic Slave Syndrome” applies historical trauma theory to the African American experience in the U.S. context. In DeGruy’s (2005) *Posttraumatic Slave Syndrome: America’s Legacy of Enduring Injury and Healing*, she provides a historical context for understanding the negative perceptions, images, and behaviors many African Americans experience as result of slavery. She traces the historical effects of American chattel slavery on African Americans and how African Americans have adapted their behaviors over the centuries in order to survive the effects of chattel slavery. She proposes the concept of Post Traumatic Slave Syndrome (PTSS) to conceptualize the current lived experience of many African Americans is related to trans-generational adaptations linked to past traumas of slavery and on-going oppression (p. 13). DeGruy defines PTSS as:
A condition that exists when a population has experienced multigenerational trauma resulting from centuries of slavery and continue to experience oppression and institutionalized racism today. Added to this condition is a belief (real or imagined) that the benefits of the society in which they live are not accessible to them. This, then, is Post Traumatic Slave Syndrome:

**Multigenerational trauma together with continued oppression and Absence of opportunity to access the benefits available in the society leads to…**

**Post Traumatic Slave Syndrome. M + A = P** (p. 121).

Consequently, she argues that there are resulting common patterns of behaviors associated to PTSS. She identifies three categories: (a) Vacant esteem; (b) Ever present anger; and (c) Racist socialization. The following paragraph briefly describes these three categorical distinctions.

Vacant esteem relates to a belief that an individual has little or no worth. This belief of having little or no worth has been influenced by three levels: society, community, and family. Society contributes to vacant esteem in a variety of ways from laws, institutions, and policies, as well as how African Americans are portrayed in the media. African Americans are disproportionally represented in the judicial system (Alexander, 2010). Racial bias and lethal force against African Americans in policing is a systemic problem across the U.S. Some resent examples currently in the media include the shootings of unarmed Michael Brown in Ferguson, MI and John Crawford in Ohio as well as the chocking death of Eric Garner in New York for allegedly selling untaxed cigarettes. African American often live in segregated neighborhoods, and schools are substandard. African Americans have more difficulty obtaining bank loans and often
have to pay higher interest rates to secure a home loan (DeGruy, 2005). To put it another way, vacant esteem arises and is influenced by the various systems (e.g., Bioecological Model) with which an individual interacts on a daily basis as well as the historical context. As a result, vacant esteem can be passed down through generations in the form of parenting styles.

DeGruy contends that “ever present anger,” the next category associated with PTSS, is the most prominent behavior pattern related with PTSS. She suggests that the anger manifests from ongoing oppression from the dominant group, where “goals are blocked” and there is a fear of failure that exists in the African American community. An example that DeGruy points to, which she says has perpetuated “blocked goals,” is the fallacy that African Americans have been fully integrated into the greater society. This year, 2015, marks the 50th anniversary of “bloody Sunday” and the march over the Edmund Pettus Bridge in Selma, Alabama. The protest for equality and justice for minority groups has only been partially realized, as evident by the disparities that exist in educational opportunities, the judicial system, and bank lending practices in the United States, to name a few.

The last category is racist socialization, which DeGruy considers “the most insidious and pervasive symptom” of PTSS (p. 134). Racist socialization represents the social construction of a value system related to class and race/ethnicity, where “Whiteness” is superior to “Blackness.” This is similar to W.E.B. Du Bois’ “double consciousness,” which he articulates in “The Souls of Black Folk” (1903). DuBois suggests that not only do “Black folk” view themselves through their own Black identity, but they also view themselves or their community through White eyes. As a net result of
the trauma from Chattel slavery, residuals have been passed down through the
generations, socializing African Americans that they were inferior “physically,
emotionally, spiritually, and intellectually” (DeGruy, p. 137). For many in the Hill
District, the residuals from transgenerational trauma associated with slavery and
DeGruy’s conceptualization of PTSS will add another dimension and insight into the
lived experience of community trauma in this community.

Social Cognitive Theory: Agentic Perspective

Social cognitive theory suggests that individuals are active participants (i.e.,
agents) in their environment where each individual’s thoughts are not “disembodied,
immaterial entities that exist apart from neural events” (Bandura, 2001, p. 4). An
individual is not merely a computer that only reacts to different commands or stimuli
from the environment, but an organism that actively explores, manipulates, and
influences his or her environment. These interactions are bidirectional transactions.
Individuals are producers as well as products of sociocultural influences (Bandura, p. 1).
In many respects social cognitive theory is about being human. In other words, what will
give an individual’s life meaning and purpose?

According to Bandura, human agency has four core features: intentionality,
foresight, self-reactiveness, and self-reflectiveness. To act intentionally is to use an
individual’s agency. The core feature is foresight which is future-orientated. Through
foresight, an individual is motivated to act based on potential desired outcomes.
Bandura (2001) states, “The ability to anticipate outcomes to bear on current activities
promotes foresight behavior. It enables people to transcend the dictates of their
immediate environment and to shape and regulate the present to fit a desired future” (p.
7). Self-reactiveness refers to an individual’s ability to regulate his or her motivation, affect, and actions based on proximal and distal goal and value system. Self-reflectiveness is an individual’s ability to reflect metacognitively on his or her ability and belief about having some control over behaviors and the environmental events. A part of the self-reflectiveness is the idea of perceived self-efficacy (Bandura, 1994). Self-efficacy affects how an individual feels, thinks, is motivated, and behaves. “Efficacy beliefs play a central role in the self-regulation of motivation through goal challenges and outcome expectations” (p. 10). Efficacy beliefs influence an individual’s outlook about life, whether he or she interprets the world “pessimistically or optimistically,” and ultimately whether those beliefs are “self-enhancing or self-hindering” (p. 10). In addition, social cognitive theory takes into account that in some spheres of functioning, individuals do not have control over their social conditions and need “proxy” agency. Proxy agency is a socially mediated mode of agency where individuals seek wellbeing and safety through a community agency. For example FOCUS Pittsburgh could be seen as a proxy agency, helping individual gain the knowledge, skills, or resources needed to secure a certain quality of life and foster personal agency.

Theories of Motivation

Self-Determination Theory (SDT). SDT postulates three innate psychological needs that are the basis for a person to grow, to be motivated, and to be integrated (Ryan & Deci, 2000). The three psychological needs are competence, relatedness, and autonomy. SDT asserts that, “if the social contexts in which such individuals are embedded are responsive to basic psychological needs, they provide the appropriate
developmental lattice upon which an active, assimilative, and integrated nature can ascend” (p. 76).

**Maslow’s Hierarchy of Needs Model.** In addition to SDT, Maslow’s Hierarchy of Needs Model (1971) illustrates the basic building blocks for an individual to actualize their potential. Maslow’s Hierarchy of Needs is illustrated as a pyramid. The base of the pyramid includes the basic physiological needs to live and survive, such as food, sleep, water, and homeostasis. The second tier would be safety and security needs, such as protection from crime, health, poverty, employment, adequate resources, property, and family. The third tier is love and belonging, and includes interpersonal relationships and sexual intimacy. The fourth tier is Esteem and illustrates an individual sense of worth and confidence. The top of the pyramid is self-actualization, meaning an individual is able to recognize their potential and has acquired the knowledge, skills, and resources to fulfill their potential. In this context, Maslow’s Hierarchy Needs not only highlights what an individual needs to develop and reach their full potential, but also what a community requires to thrive. A community that can provide the basic physiological needs and safety for its residents as well as provide an environment that fosters a sense of belonging and esteem lays the foundation for individuals not only to survive, but to thrive.

**Narrative Construction Meaning-Making Identity**

Singer (2004) outlines the development of narrative identity and current research trends that study meaning-making. In narrative identity, each individual is viewed as a unique social being in the world seeking further understanding of how an individual searches for meaning, and learning what influences meaning making (i.e., culture, life stage, gender, ethnicity) in a narrative construction (Singer, 2004). Singer (2004)
identifies four common principals in the research (a) the centrality of narrative to identity formation, (b) the role of cognitive-affective processes, (c) an emphasis on lifespan developmental approach, and (d) sociocultural factors. According to Singer (2004), how an individual constructs his or her narrative is paramount to identity formation. Emphasizing, an individual’s developmental stage and sociocultural context contributes to the construction of meaning-making identity. For example, a meaning-making narrative construction by a 15 year-old African American who experiences a rape and comes from a disadvantaged urban neighborhood will likely be different from a 40 year-old Caucasian woman from a privileged neighborhood who experiences a rape. The literature suggests that both females will be influenced by their sociocultural context and developmental stage in processing the trauma experience into a personal narrative (Singer, 2004). Part of the elusive processes dwells in the cultural context of the females’ past, present, and future meaning constructed for each narrative. Singer contends that an integrated narrative identity across the lifespan brings us (the counseling profession) “closer to the actual lived lives and expressions of sorrow and growth” (Singer, 2004, p. 454).

The literature demonstrates the importance of traumatized individuals sharing their story as a process of constructing their narrative to give meaning to the trauma, as well as integration of the trauma as a means of recovery, new identity, and reconnection with others (Park, 2010). In a study on meaning making with cancer survivors, Park, Edmondson, Fenster, and Blank (2008) reported how “few studies have distinguished between meaning making coping processes and the outcomes of those processes” (p. 873). This study suggests that the distinction between meaning-making coping processes
and “meaning made” is central to gaining insight into an individual’s assessed meaning of a stressor and the integration of that meaning into the individual’s worldview. The authors report three main outcomes for coping with life stress: (a) positive life changes or posttraumatic growth, (b) deepened sense of meaning in life, and (c) restoration of core beliefs (Park, et al., 2008). Also, the authors report that further research needs to be done in meaning-making processes. The literature is consistent in reporting the significance of an individual’s ability to construct meaning in the recovery process. Less is known about the possible influence of environmental factors on how an individual processes the trauma into his or her narrative story, resulting in meaning, growth, or well-being.

Murphy, Moynihan, and Banyard (2009), in their qualitative study of survivors of sexual assault, uncovered three relational themes, “breaking down, making meaning, and going beyond themselves” (p. 161). This can be visualized as a spiral. The image of the spiral represents the circular movement in trauma recovery where for some there is “[not] necessarily an end” (p. 161). Participants in the study moved up and down as well as oscillating back forth between the trauma experience and trying to make meaning of the trauma in the spiral. Breaking down describes the violence and victimization of the women, which caused the women to go down the spiral creating distressed symptoms. Meaning making was a way up the spiral and illustrates the ways in which the women were able to integrate the assault into a personal narrative. Going beyond represents what the women did with their story, who they would share their story with, as well as what they wanted. This study highlights the importance of understanding individual responses to trauma within the wider content of “biopsychological factors.”
Brief History of Psychological Trauma

This study does not warrant an exhaustive history of the development of psychological trauma, but rather highlights the origins of investigating trauma and some of its major trajectories pertinent to my research. Judith Herman in her seminal book, *Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror* (1992/1997), details the development of the study of psychological trauma, which began in the late 19th century. According to Herman, the development of psychological trauma has had a checkered past that was often tied to the political will of the time period, as well as a particular psychological trauma that surfaced into the public consciousness. Herman identifies three major forms of psychological trauma that entered into public consciousness between the years 1880-1980.

The first was the French neurologist Jean-Martin Charcot (1825-1893) who worked at the Salpêtrière, which was a large asylum in France that housed the outcasts, individuals who were consider to exhibit deviant behavior that did not fit into the social norms of the time, or were considered “insane.” It was at the Salpêtrière that Charcot began his study of “hysteria” in women. Charcot’s work discredited the idea that a hysterical woman was a malingerer, but that her symptoms were psychological and related to trauma. Soon Charcot’s work became widely know and respected, so much so, in the 1890s Pierre Janet (1859-1947), William James (1842-1910), and Sigmund Freud (1856-1939) joined Charcot at the Salpêtrière to learn and study under him (Golstein, 1987). Just as the fever and passion to study hysteria had started twenty years earlier, by the 1900s, the political will to continue to listen to women, validate their trauma experiences, and investigate root causes of hysteria faded, and the political elite began to
discredit the research to uphold the patriarchal ideology of the time (Herman, 1992/1997).

The second, psychological trauma to hit the public consciousness was the tragedy of the First World War where eight million men perished in four years. British psychologist Charles Myers coined the term “shell shock,” as a way of conceptualizing the psychological trauma the soldiers endured as result of prolonged exposure to the violence of war (Myers, 1940). Ironically, shell shock was similar in nature to hysteria in men (Herman, 1992/1997). Again, a few years after the war ended the interest in studying psychological trauma dissipated. Some years later an American psychiatrist, Abram Kardiner (1891-1981) began to work with veterans and developed the clinical outlines of the traumatic syndrome we use today (Kardiner, 1947). In 1970 two psychiatrists, Robert Jay Lifton (1926- ) and Chaim Shatan (1924-2001) began to work with Vietnam veterans who were against the war. These veterans organized “rap groups” for the purpose of veterans to be able tell their traumatic stories (Lifton, 1973). By the mid-1970s hundreds of these rap groups had formed around the country and pressured the US government to create a psychological treatment program for veterans. With pressure from veterans, a program called Operation Outreach was created and was housed within the Veterans’ Administration, and outreach centers were set up all over the country. Finally, in 1980 after years of pressure from veterans and 100 years after Charcot began studying hysteria, “post-traumatic stress disorder” (PTSD) was included in the Diagnostic and Statistical Manual (DSM) the official manual for mental disorders.

The last major psychological trauma to emerge into public consciousness had nothing to do with the study of combat veterans but was rather a return to Charcot’s study
of hysteria and the often hidden lives of women experiencing domestic and sexual
violence. The Women’s Liberation Movement (e.g., Freeman, 1975; Reger, 2004) of the
1970s raised public awareness in similar ways to the rap groups started by the veterans.
These safe places for women to tell their story empowered them to collectively overcome
the social barriers of shame, denial, and secrecy to name their injuries. The results from
this intentional social consciousness raising led to public speak-outs against rape and
legislative rape reforms, the first international tribunal on crimes against women, and the
first rape crisis centers were opened, to name a few. Herman posits that only after combat
veterans legitimated the concept of PTSD, was the psychological symptoms seen in
women who were survivors of rape, domestic abuse, and incest were acknowledged
because they were basically the same as combat veterans experiencing PTSD.

It was not my intent in this short summary of the development of a
conceptualization of psychological trauma to give an exhaustive history of trauma, but
rather acknowledge the waxing and waning of interest and complex history associated
with understanding psychological trauma. Within my research findings, I highlight the
relationship between the study and treatment of psychological trauma and community
and public consciousness raising. The following paragraphs will outline current
definitions and constructs of trauma.

**Defining Trauma**

**Diagnostic and Statistical Manual of Mental Disorders (DSM-5)**

The new 5th Diagnostic and Statistical Manual (DSM 5, 2013) moved
Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) from the chapter
on anxiety disorders to its own chapter. The move signifies recognition of the breadth of
reactions an individual can have to an external stressor. For an individual to be diagnosed with PTSD, symptoms from four symptom clusters must be present. The symptom clusters include: (a) intrusion (e.g., intrusive memories, distressing dreams, flashbacks), (b) persistent avoidance of memories, thoughts, or feelings surrounding the traumatic event, (c) negative alterations in cognition and mood (e.g., numbing, cognitive distortion, detachment), and (d) arousal symptoms (e.g., aggression, problems concentrating, reckless or self-destructive behavior). Duration of symptoms is the only difference between PTSD and ASD. PTSD is diagnosed if symptoms last for more than one month after an external traumatic event, ASD can last no more than one month. Also, new to the DSM 5 is the initial stressor criterion specifies whether the trauma was experienced, witnessed, or experienced indirectly. Although, the new DSM 5 broadened the concept of trauma and stressor related disorders, the construct is still limited in its attempt to fully capture the subjective nature of trauma.

**Limitations of DSM 5 PTSD Construct**

Briere and Scott (2006) and Levers (2012) state that defining trauma into a set of constructs or diagnostic criteria is difficult and incomplete. Trauma experiences are subjective, making it difficult to quantify the experience objectively. Kirmayer states, “PTSD is a limited construct that captures only part of the impact of violence, ignoring issues of loss, injustice, meaning and identity that may be of greater concern to traumatized individuals and their families and children or later generations” (2007, p. vi). Kirmayer’s critique of the PTSD construct suggests concentrating on quantitative data points in an attempt to objectify stress reactions to traumatic events can miss the social impact on a community or family, as well as the subjective meaning making processes,
which can be of more importance to trauma survivors. Noting that DSM construct is limited in capturing the subjective nature of trauma, a phenomenological perspective will help to capture the subjective nature of trauma.

**Phenomenology of Trauma**

Traumatic events can destroy an individual’s understanding of his/her assumptive world (Janoff-Bulman, 1992), relationships, and the community. Herman (1992/1997) states that a traumatic event, “violates the victim’s faith in a natural or divine order and cast the victim into a state of existential crisis” (p. 51). Trauma can alter the very existence and meaning that an individual gives to his or her life (Frankl, 2006). These existential influences can hinder an individual’s ability to trust, hope, care for his or herself or others, resulting in a “disconnect” between an individual’s perceived sense of self, as well as relationships with others (Herman, 1992/1997). Trauma can attack the core of an individual’s normal living mechanisms and cause the individual to retreat into the self or to become isolated from others.

The existential crisis that can occur as the result of trauma can situate an individual into a state of “nonbeing.” Working from the assumption that trauma can cause an existential crisis, a brief exploration of “being” is warranted. Martin Heidegger’s (1927) hermeneutic phenomenological conceptual framework suggests that an individual’s “being” is never separated from the world. Rather, the person (i.e., Dasein) is thrown into the world without a choice (facticity), whereas the self (existence) is a being-in (the self-world relationship), thus a person is a “being-in-the-world” (Sempera, 2007). Stemming from Heidegger’s idea of Dasein, May (1994) articulates being as a noun or “potentia,” which is “being” as a source of potential or in process of becoming.
Phenomenologically, an individual’s existence is always in relationship to his or her world (objects), body, others, and time (i.e., Lifeworld Existentials), or as May (1994) classifies the “Umwelt [objects], Mitwelt [body], and Eigenwelt [others].” The discovery of self as a “being-in-the-world” is built upon an individual’s understanding and interactions with the world around him or her. A traumatic experience can shake the foundation of an individual’s assumptive world (Janoff-Bulman, 1992), possibly severing an individual’s “being-in-the-world,” or disrupt the forward movement of realizing the individual’s potential. For many residents of the Hill District, trauma informs their understanding of the world and how they interact with their environment, as well as how the environment informs them developmentally. Identity formation and the ability to reach or recognize an individual’s potential are based in large part on the meaning-making relationship to the community. If an individual feels that he or she has no potential, their being can become static or distressed. If he or she views their community as distressed, one can view the self as distressed and static.

**SAMHSA Trauma Framework**

The Substance Abuse and Mental Health Service Administration (SAMHSA, July 2014) developed an inventory of trauma definitions and concluded that there were too many “subtle nuances and differences” to create one definition. Instead of a definition, SAMHSA created a common trauma framework to be shared by its constituents. The following framework was generated:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and
SAMHSA’s move from trying to define trauma to creating a common working
conceptual framework could be considered a paradigm shift from a purely objective
construct to a fuller understanding of the subjective nature of trauma experiences.
Gaining insight into the subjective processes of trauma, focusing on the relational
attributes of an individual’s experience of traumatic experiences within the community,
culture, and environment will produce a richer interpretation of the subjective nature of
trauma.

**Complex Trauma**

For many African Americans in the Hill, their trauma started when they were
children and took on many forms of interpersonal trauma. Examples of these forms of
interpersonal trauma include sexual abuse, physical and verbal violence inside the home
or outside the home, and being rejected or discriminated against because of skin color.
The term “complex trauma” is used in the literature to describe the impact multiple layers
of interpersonal traumatic experiences can have on the development and identity
formation of an individual (Courtois & Ford, 2013). Complex trauma occurs when the
stressor event is repeated over time and/or perpetrated by a family member or an
authority figure, which usually begins in childhood or adolescents, but also can occur in
adulthood.

The effects of complex trauma are rooted in the nature of attachment between
child and primary caregivers. Children who live in a secure and safe environment learn to
trust their feelings and the world around them. Through the modeling of a primary
caregiver, children learn a complicated vocabulary to describe emotions effectively. This learned emotional vocabulary and a trust in the primary caregiver’s ability to restore a sense of control and safety when a child is distressed, moderates against “trauma-induced terror” (van der Kolk, 2005). The opposite is true in an insecure environment and with primary attachments that have not established a sense of trust and safety in the child. Children who are in extreme distress and where no relief from the stress can be found, because either the primary caregiver is the source of the distress, or was unable to model emotional regulation or an emotional vocabulary, fosters an environment where the child lacks the ability to process, integrate, or categorize what is happening. If a child feels helpless and lacks any sense of stability or control, the primal brain can be triggered (i.e., fight/flight/freeze) and the child is not able to learn from the experience (van der Kolk, 2005). The inability of the child to process, integrate, or categorize the stressor(s), and the repeated nature of complex trauma can lead to a constant state of being in a psychological and biological “survival” mode (Courtois & Ford, 2013). Over time, if the victimization continues or recurs, these survival reactions can be ingrained in the individual’s personality as they develop. Survival can become the primary vehicle an individual conceptualizes his or her being in the world, affecting personal relationships and their ability to self-regulate their emotions. As a result of an inability to self-regulate, maintain relationships, and being stuck in survivor mode, many survivors of complex trauma seek other coping mechanisms to self-soothe. Some of these coping mechanisms include alcohol and drug abuse, self-harm, and suicidality (Najavits 2006; van der Kolk, Perry, & Herman, 1991). Survivors of these early life traumas often struggle with anger, alienation, distrust, confusion, grief, low self-esteem, loneliness, shame, and self-loathing.
(Courtois & Ford, 2013). In addition to the psychological effects of layers of trauma, adverse childhood experiences has been linked to disease and early death.

**The ACE Study.** The Adverse Childhood Experiences (ACE) study (1995-1997) is the largest study to date, with more than 17,000 participants, which has linked health risk behavior and disease in adulthood to exposure to emotional, physical, or sexual abuse, and household dysfunction during childhood (Felitti, et al., 1998). The study found that nearly two-thirds of all respondents had at least one adverse childhood experience and 12% of the respondents had four or more adverse childhood experiences. The study also found a strong graded relationship to the amount of exposure to abuse or household dysfunction and multiple risk factors associated with some of the leading causes of death in adults. The ACE study found a significant relationship between adverse childhood experiences and alcoholism, drug abuse, sexual promiscuity, sexually transmitted diseases, intimate partner violence, obesity, physical inactivity, depression, suicide attempts, and smoking. Further, the more adverse childhood experiences reported, the more likely a person will develop heart disease, cancer, diabetes, liver disease, stroke, and skeletal fractures. The ACE study illustrates that adverse childhood experiences are more common than acknowledged; it shows the impact that these adverse experiences have on physical and behavioral health later on in life and thus the need for preventative interventions.

Complex trauma describes the experience of multiple, chronic, and prolonged, adverse interpersonal traumatic events that usually occur in childhood. These experiences usually occur within the child’s primary caregiver system affecting the child’s ability to emotionally regulate, feel safe, trust, and make sense of what is happening to them. The
effects of multiple adverse experiences are related to multiple risk factors leading to physical and behavioral health problems. In addition, complex trauma does not only relate to individual victimization, but can also exist in the context of the community.

**Community Trauma**

In the literature, community trauma is often associated with the impact of a particular event or events have on a community. Some examples include, chronic community violence, workplace and school violence, natural and manmade disaster, war, genocide, and terrorism (Levers & Buck, 2012; Herman, 1992/1997). Even though individual traumatic events happen in the context of a community, the term community trauma will refer to any form of violence that affects a number of people or an entire community. The World Health Organization (WHO) (1996) defines violence as, “the intentional use of physical force or power, threatened or actual, against another person or against a group or community that results in or has a high likelihood of resulting in injury, death, psychological harm, maltreatment, or deprivation.” This definition of violence is intentionally broad in scope covering a wide range of violent acts toward an individual or community that go beyond outcomes of injury or death. This definition better illustrates the sometimes hidden acts of violence those in the majority in our society do not experience or acknowledge, but many in the Hill and other urban communities experience on a daily basis (Liebschutz et al., 2007; Alim et al., 2006; Breslau et al., 1998). Some examples of these hidden acts of violence experienced on a daily basis in the Hill include racism, low socioeconomic status (SES), poverty, and substandard educational opportunities.
In a recent qualitative dissertation Katy Sampson (2009) explores the contextual nature of community care from a community psychology perspective in an urban neighborhood similar to the Hill District. Her study highlights the influence of systemic issues such as economics, place, power, and discrimination can have on the individual’s (i.e., client) subjective meaning (i.e., identity), as well as ecological factors. An unanticipated theme identified in her study was the prevalence of the term “community trauma,” which was used by all the clinicians she interviewed for her study. “Staff interpreted their observations of suffering, stories of victimization and violence, family disruption and fragmentation, and spiritual struggles as evidence for the existence of what they called ‘community trauma or community PTSD’” (Sampson, p. 159). There are a number of studies and empirical data (Breslau, 2004; Herman, 1992; Jones, 2007; Levers, 2012; Mabanglo, 2002; McFarlane, 1987) that focus on the impact of traumatic events experienced by a community, but the context for which “community trauma” is used is different from the way the staff members in this study used the term. There is a gap in the literature addressing the idea of “community trauma” as described by the staff interviewed in Sampson’s (2009) study. She explains the community trauma to which the staff members are eluding too is influenced by historical events such as slavery, the demolition of family homes, and the community’s business district for Urban Renewal in the 1950’s, as well as institutional racism. Sampson states that “community trauma,” as defined by the staff members, was the primary context for which clinicians conceptualized clients. However, the study only includes interviews from clinical staff, as opposed to clients or key stakeholders from the community. Therefore, the definition is solely from a community psychology perspective. The term community trauma as
referenced in the literature is usually associated with a particular traumatic event (e.g., collective trauma), such as a hurricane, an industrial accident, war and genocide, mass shooting, or act of terrorism. My research suggests multidimensional origins that are caused not by one particular event but rather by multiple contributing factors, which also have the potential to be barriers to seeking treatment.

**Trauma-Informed Approach**

In recent years, there has been recognition of the importance of having an informed trauma background in multiple service systems to help decrease the potential for re-traumatizing individuals. In 1994 SAMHSA (July, 2014) held a “Dare to Vision” Conference that brought together women trauma survivors to tell their stories and experience of recovery. What was learned from this gathering was that the women experienced triggered memories of abuse, and re-traumatization occurred through standard hospital practices. Over the last 20 years, SAMHSA has been researching and working on developing a *Trauma-Informed Approach* (July, 2014) that can be used across a variety of service sectors as a way to help resolve trauma related issues. Some examples of agencies are child welfare, criminal and juvenile justice, primary health care, and the military. SAMHSA reports that trauma researchers, practitioners, and survivors suggest that having only trauma-specific interventions is not enough to improve treatment or healing for trauma survivors or change service systems business practices that have the potential to re-traumatize.

The framework of “trauma-informed care” or “trauma-informed approach” is based on four assumptions (i.e., the four R’s) and six key principals. The four assumptions are: (a) Everyone at all levels of an organization or system have a basic
realization about trauma and the effects trauma can have on individuals, families, groups, organizations, and communities; (b) Individuals in the organization or system recognize the signs of trauma; (c) The system, organization, or program “responds by applying the principles of a trauma-informed approach in all areas of functioning;” and (d) resist re-traumatization of clients and staff. The six key principles are: (1) Safety – which includes physical as well as psychological safety; (2) Trustworthiness and Transparency – organizational operations and decisions are performed in a transparent manner to build trust among staff, clients and families; (3) Peer Support – often referred to “trauma survivors” who aid in the recovery process; (4) Collaboration and Mutuality – places importance of leveling power differentials that can exists between staff and clients or professional staff and volunteers; (5) Empowerment, Voice and Choice – “the organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery of trauma” (p. 11); and (6) Cultural, Historical, and Gender Issues – the organization moves beyond stereotypes and biases, recognizes the healing value of traditional cultural connections, culturally sensitive and appropriate policies and procedures, as well as recognize and address historical trauma. A trauma-informed approach recognizes the pervasive impact trauma experiences can have on individuals at all stages of life and communities. Trauma- specific interventions primarily utilized in specialized clinical settings might only be effective for those who seek treatment, have access, and/or realize their physical or mental distress may be related to a traumatic experience. Further, many individuals who experience trauma first present to a non-mental health service provider, such as primary health care, judicial system, educational system, or child welfare. A
trauma-informed approach fosters a holistic methodology to prevention and trauma interventions across multiple service systems and organizations to ease trauma related issues.

**Mental Health Disparities in Ethnic/Racial Minority Groups**

National surveys (Kataoka, Ahang, & Wells, 2002; Kessler et al., 1994; Harding et al., 1987; SAMHSA, 2013) have shown that approximately one in five Americans will have a mental health problem in any given year, but only one in three will receive or seek mental health services. Furthermore, “of the 45.9 million Americans 18 and older who have mental health conditions, just 17.9 million receive treatment” (SAMHSA, 2013). These statics are even greater in racial/ethnic populations. In a recent study by the Center for Disease Control, disparities in mental health care treatment between Whites and African Americans have increased significantly since the 1990s (Primm, et al, 2010). The Minority Health and Health Disparities Research and Education Act of 2000, defines disparities as, “differences in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival.” The research suggests that social determinants may influence disparities. Some of these social determinants include poverty, access to resources, education, institutionalization, and housing status (Primm, et al, 2010). Racial/ethnic populations are more likely to experience low SES, which has significantly been linked to mental illness (SAMHSA, 2015). The U.S. Census predicts by 2042 racial/ethnic minorities will surpass Whites as the majority population, yet minority populations continue to remain underserved in the current mental healthcare system (US Department of Health and Human Services, 2003).
The literature on mental health disparities is conclusive that ethnic/racial disparities do exist in the mental healthcare system (Ault-Brutus, 2012; Primm, et al., 2010). In contrast, less consensuses exists in the literature as to primary constructs that contribute to ethnic/racial minority disparities (Hunt et al., 2013; McGuire & Miranda, 2008; Kessler et al., 1994; Chow, Jaffee, & Snowden, 2003). Some of these barriers to treatment highlighted in the literature include; stigma, racism, poverty (Hines-Martin, Malone, Kim, Brown-Piper, 2003; Snowden, 2012; Chow, Jaffee, & Snowden, 2003), insurance (Snowden, 2012; Samnaliey, McGovern, & Clark, 2009), and residential segregation (Dinwiddie, Gaskin, Chan, Norrington, & McCleary, 2013). In following paragraphs, I will review the literature on stigma, chronic community violence, social determinants, and racism as they relate to my findings.

**Stigma**

Stigma has been reported as one of the primary barriers to treatment by SAMHSA (2013) and the WHO reported in their 2001 annual report the brutal effects stigma can have on millions of people who suffer from mental illness. As reported in chapter one, the literature on attitudes and beliefs of ethnic/racial minority groups in relation to seeking mental health treatment are paradoxical and inconsistent. Some studies show that stigmatizing attitudes are a barrier to treatment (e.g., Anglin et al., 2006; Fogel and Ford, 2005; Rao et al., 2007), while other studies claim the opposite (e.g., Diala et al., 2001; Givens et al., 2007). A recent study by Jimenez et al. (2012) found no significant difference in attitudes or beliefs between African Americans and non-Latino Whites regarding the use of mental health services. Noting that the literature is inconsistent on
the influence stigma may have on barriers to treatment, exploring stigma from various perspectives may generate more insight into the phenomenon.

Corrigan and Ben-Zeev (2011) separate stigma into four levels. The levels include, public stigma, self-stigma, label avoidance, and structural stigma. Public stigma relates to large social groups who support stereotypes about individuals with mental health issues and act against them. Self-stigma is the effect from public stigma whereby individuals internalize the negative stereotypes, resulting in lower self-esteem and self-efficacy. Label avoidance arises when an individual chooses not to seek treatment, because he or she does not want to be labeled due to the possible suffering from the prejudices as a result of the label. Structural stigma relates to intentional discrimination by private and governmental institutions as well as policies that can restrict opportunity for individuals with mental health issues. Corrigan and Ben-Zeev’s articulation of the levels of stigma may give insight into the paradoxical results in the literature. In that, stigma can be filtered through the context of an individual’s ecology. Similar to Bronfenbrenner’s Bioecological Model, Corrigan and Ben-Zeev’s four levels of stigma relate to the micro and macro-social levels. The micro is the individual social cognitive processes of public stigma, self-stigma, and label avoidance. The macro-social level relates to structural stigma, in other words, social phenomena of stigma. The literature is clear that stigma can be barrier to treatment, but the extent to which it may keep an individual from seeking treatment is less clear. Looking at stigma from multiple levels could help to refine and expand how stigma maybe perceived in the Hill community.
Social Determinants

The Hill District is made up of five neighborhoods: Bedford Dwelling, Crawford-Roberts, Middle Hill, Terrace Village, and Upper Hill. Some of these neighborhoods within the Hill District, for example Bedford-Dwelling (12%) and Middle Hill (13%) have double the unemployment rate in relation to the city of Pittsburgh’s unemployment rate of 6% (The Looking Glass Institute, 2008). The median income in the Hill community is around $15,000.00 (The Looking Glass Institute, 2008). The federal government 2013 poverty guideline for a family of four is $23,550.00 (U.S. Department of Health and Human Services). High school graduation rates for the Hill District are 69% compared to 81% for the city of Pittsburgh (The Looking Glass Institute, 2008). In addition, only 11% of the Hill District population obtained a bachelor degree or higher, compared to 26% of the population of residence living in the City of Pittsburgh.

For many in the Hill District land and home equity have been a source of trauma and struggle beginning in 1950s when over 8,000 residence were removed by eminent domain to build the Civic Arena, igniting a 60 year population drop of 75%. The statistics on housing indicate 72% of housing in the Hill District is renter occupied (The Looking Glass Institute, 2008). In addition 22% of housing stock is vacant (The Looking Glass Institute, 2008). Further, in the 1990’s 40% of all public housing in Pittsburgh was in the Hill District (The Looking Glass Institute, 2008). It is worthy to note that almost all the public housing in the Hill District has been replaced or is in the process of being replaced by new mixed-income housing, which has created varying responses from the community. Some report the new housing has given many in the community an opportunity to move out of substandard housing and into newer, safer, more adequate
housing. Others report, however, the demolition of the housing projects has displaced many of the residents, forcing them to move outside of the city to find affordable housing. For many, the new housing developments are a form of re-gentrification of the community.

I hypothesize the statistics detailing housing inequality, poverty rates, suboptimal education or opportunity, homelessness, higher rates of incarnation, and unemployment is contributing to the conceptualization of community trauma in the Hill District. Social determinants have been linked to health disparities in the U.S., but also can weaken protective factors, such as social supports, that can lessen the development of mental illness. For many in the community, the reality of these social determinants exasperates the effects of community trauma as summed up by the following quotes, “just living day-to-day is hard,” or “we are just trying to survive.” This belief system of survival taps into the primal brain mechanism of “fight/flight/freeze” responses, which can perpetuate trauma responses in this community similar to the idea of compounded community trauma and complex trauma.

Racism

African Americans report more incidences of racism than any other racial/ethnic minority group in the U.S. (Kessler, Mickelson, & Williams, 1999; Pieterse, Todd, Neville, & Carter, 2012). Jones and Carter (1996) define racism in the following way:

Racism as the transformation of racial prejudice into individual racism through the use of power directed against racial group(s) and their members, who are defined as inferior by individuals, institutional members and leaders, and which is
reflected in policy and procedures with the intentional and unintentional support and participation of the entire race and dominant culture (p. 3).

While racism is based on the macro prejudices to the micro individual prejudices, discrimination involves direct harmful actions and behaviors towards a person or group(s) because of their secondary social status. For the majority of marginal and oppressed populations, disparities and unjust treatment can be part of their daily existence (Pieterse, Todd, Neville, & Carter, 2012). For this reason, “perceived” racism could happen at the interpersonal, institutional, or cultural level creating distress in an individual and/or group of people. Being that African Americans have reported more incidences of racism than any other racial/ethnic minority group, it is believed that racism is a source for health disparities in this population (Pieterse, Todd, Neville, & Carter, 2012). For example, African Americans have higher rates of hypertension, which can be linked to stress and depression (Heard, Whitfield, Edwards, Bruce & Beech, 2011).

The literature posits a relationship between “perceived” racism among African Americans and negative psychological and physiological outcomes (U.S. Department of Health and Human Services, 2001; Smedley, Stith, & Nelson, 2003). In addition racism has been linked to lower self-esteem, which can lead to psychological distress (Chao, Longo, Wang, Dasgupta, & Fear, 2014; Marcussen, 2006). Pieterse, Todd, Neville, and Carter (2012), cited that the literature on “perceived” racism and mental health among African Americans was not conclusive. The authors did a meta-analytic review of the literature, reviewing 66 studies published between 1996 and 2011, totaling 18,140 in sample size. The study solely focused on African Americans. The results confirm the relationship between “perceived” racism and negative psychological and physiological
outcomes. The authors report a strong relationship between “perceived” racism and depression and anxiety. In addition, the amount and/or intensity of exposure to racism and the appraised stressfulness of the racist event resulted in higher reporting of mental distress. As described in my brief history of the Hill in chapter I, the community has had and continues to experience racism on multiple levels. A common theme expressed in all the focus groups in my research was the experience of racism interpersonally and at the institutional and cultural levels. Although the literature uses the term “perceived racism,” the pervasiveness of racism experienced and reported by the key stakeholders, is very real.

**Chronic Community Violence**

Violence in our country is all too often common; this is especially true in urban areas where low-income minority populations may live (Breslau et al., 1998). Research indicates that low-income African Americans living in urban settings are at a greater risk of experiencing traumatic events and have symptoms of PTSD (Breslau et al., 1998; Liebschutz et al., 2007; Alim et al., 2006). Common traumatic experiences in urban settings tend to be assaultive traumas (e.g., sexual assault, friends/family murdered) leading to greater risk of symptoms of PTSD (Breslau et al., 1998). Alim, Graves et al., in their study of 617 African Americans, found a 65% rate of lifetime trauma exposure and a 33% rate of PTSD. But the research also indicates that all to often, PTSD is under-diagnosed and untreated (Magruder et al., 2005; Swartz et al., 2005). These studies indicate a higher likelihood that low socioeconomic African Americans living in urban environments will experience assaultive traumas and have symptoms of PTSD but remain under-diagnosed, possibly because of barriers to treatment. Since the focus of this
research is on community trauma, the following paragraph will explore the experience of chronic community violence.

Horowitz, Weine, and Jekel (1995), who assessed the impact of violence on adolescent girls, found these girls experienced between 8 and 55 different types of community and domestic violent events, with a mean number of violent events of 28. Because of the volume and variety of violent experiences that these girls experienced, the authors suggest the term “compounded community trauma” to reflect the prolonged exposure and re-experiencing of violent events in their community. Violent events that were experienced in the home were also experienced in the community. One form of compounded community trauma that became evident from the research was “heard about” in relation to violent acts in the community. Their research finds that “hearing about” violent events was significantly related to meeting diagnostic criteria for PTSD. The authors contend hearing about violent events everyday can contribute to a sense of “collective traumatization.” The idea of compounded community trauma and collective traumatization reflects what many in the focus groups reported experiencing in their community. For many in this community, the frequency of hearing about violence in their neighborhood can reinforce the idea that their community does not have the resources to keep them safe. In the trauma literature, establishing “safety” is always the first step in beginning to heal from a violent experience. Chronic community violence whether experienced directly or hearing about it can significantly impede the healing process for individuals and the community.
Need For Community-Based Research

The literature calls for more community-based research to further explain racial/ethnic minority disparities in the mental health system (Hunt et al., 2012; Snowden, 2012; Snowden & Yamada, 2005). Historically, the Hill has been an enclave for racial/ethnic minority populations, and predominantly African American for the last 70 years. Racism and discrimination experienced on the interpersonal, cultural and institutional levels has the potential to influence the Hill residents understanding of self and community. Pieterse et al., (2012) empirically confirm the relationship between perceived racism and negative psychological and physiological outcomes. Sampson (2009) states that “community trauma” was the primary context for which clinicians conceptualized clients.

Summary

This chapter provided a review of the literature relevant to the lived experience of key stakeholders who are planning emergent community-based services to address community trauma in an urban neighborhood. I first reviewed my theoretical framework for the study, which included van Manen’s (1990) four lifeworld existentials. Next, I detailed Bronfenbrenner’s (1979, 2006) Bioecological Model of Human Development, historical trauma theory (e.g., Sotero, 2006), Posttraumatic Slave Syndrome (DeGruy, 2005), social cognitive theory (Bandura, 2001), two theories of motivation (Maslow, 1970; Ryan & Decci, 2000), and narrative construction meaning-making identity (e.g., Singer, 2004). These theories provided me with a lens for gaining insight to the effects of community trauma, in an attempt to make “explicit” the lived experience of key stakeholders who are planning community-based services.
The second half of the chapter focused on a review of the literature related to mental health disparities and trauma. I have included a section providing a context for this study, through a brief history of psychological trauma and the importance of public consciousness raising to affect change in behavioral health-care and public discourse. Next, I provided multiple definitions and constructs associated with interpersonal trauma and community trauma, as well as the limitations of the DSM-5 trauma construct. I also outlined mental health disparities in ethnic/minority groups, specifically stigma, racism, and social determinants. In the final two sections, I reviewed the literature related to the chronic community violence and the call from the literature regarding the need for more community-based research.
Chapter 3: Methodology

Introduction

van Manen (1990) states that phenomenological research projects require not simply that we raise a question and possibly soon drop it again, but rather that we “‘live’ this question, that we ‘become’ this question” (p. 43). For van Manen, the question must be continually revisited in its original form until it begins to reveal something of its essential nature. In other words, the question being researched is a recursive process (Levers, 2003). Counseling, like writing, is a recursive process. Phenomenological research directs the researcher not only to be constantly aware of the original question(s), but also ask him or herself, “What is it like?” What is it like to be a part of a racial/ethnic minority group and experience racial disparities in the mental healthcare system? What is it like to be an African American experiencing low SES in an urban environment and living with the effects of community trauma? What is it like for an individual accessing or not accessing behavior health services? Investigating the lived experience, the “what is it like,” has the potential to give new insight into the “malleable” barriers that this study seeks to address. Polanyi’s idea of a “comprehensive entity” can illustrate the complexity of gaining insight or discovery of a phenomenon as well as the recursive nature of analysis.

Michael Polanyi (1961) uses the term “comprehensive entity” as a vehicle for the discovery of knowledge. A “comprehensive entity” understands an object (particular parts) in relationship to the whole. Polanyi uses the example of individual blood vessels or organs in relation to the human body. For example, by dissecting a kidney, we may gain knowledge of that organ (its particulars), but we will not understand its function
until we view it in relationship to the body (Polanyi, 1961). A comprehensive entity is the
result of understanding the kidney in relationship to the whole body. Further,
“Imagination is the only way to grasp a comprehensive whole” (p. 459). Polanyi argues
that it is impossible to completely understand a comprehensive entity, because regardless
of whether an object is studied by its parts first and then the whole, or by the whole first
and then its parts, “our sense of its coherent existence is temporally weakened” (p. 460).
He continues:

   Discovery proceeds by a see-saw of analysis and integration similar to that by
which our understanding of a comprehensive entity is progressively deepened.

   The two complementary movements are here a search for the joint meaning of a
set of particulars, alternating with a search for the specification of their hitherto
uncomprehended meaning in terms of yet unknown particulars (p. 464).

Gaining insight into the “malleable” barriers to treatment and community trauma is a
“see-saw” of analysis. In the literature many particulars, such as “perceived” racism,
stigma, social determinants, and chronic community violence have been linked to
contributing to mental health disparities in racial/ethnic minority groups. A
phenomenological qualitative inquiry is a “see-saw” of analysis of the lived experience
and has the potential to generate a fuller understanding of the questions under study.

   This study seeks to illuminate and parse out the lived experiences of Hill District
key stakeholders experience of community trauma and potential barriers to healing and
recovery. The guiding question for my research project is, “How does community trauma
affect social as well as individual recovery and the process of recovery in the community
context?” The study highlights the “nested” quality of the individual in the context of
multiple systems in the community and provides pertinent information to help guide community-based services in the Hill District. The study uses a participant action research approach. The results of the study are already being applied to the planning and implementation of community-based services that will be discussed in chapters IV and V. Unlike a traditional study, in which the researcher comes into a community with research questions in hand, this study began and germinated with and from the Hill community.

In this chapter I will present the conceptual framework for the study. I will describe my research design, participants and sampling, and methods and procedures. Included in the multi-methods approach and procedure section, I will describe my use of rapid assessment process (RAP), the consultative workshop method an extension of focus groups, participant observation (PO), and participant action research (PAR). Finally, I will describe my instruments, data collection, and recording procedure.

**Conceptual Framework**

My qualitative study used a phenomenological approach to gain insight into phenomenon associated with lived experience of community trauma in an urban context and potential barriers to recovery and healing. The study used van Manen’s Hermeneutic Phenomenological Reflection as a mode for conducting thematic analysis (1990). The use of this approach is most appropriate in trying to understand meaning (phenomenological themes) behind the lived experience. Phenomenological research attempts to get at the “essence” of a phenomenon by bringing the phenomenon into the light, describing ecologies, and revealing the “internal meaning structures” of the lived experience. To make explicit the very subjective nature of key stakeholders’ experiences of community trauma, a sensitive phenomenologically oriented theoretical framework is needed. van
Manen’s *Lifeworld Existentials* gives the researcher a framework for researching sensitive topics.

The four *lifeworld existentials* themes that guide the inquiry are “lived space, lived body, lived time and lived other.” Lived space is not only the physical space a person resides in, but it also is how an individual experiences his or her being in the day-to-day activities of his or her life. Lived space is largely pre-reflective, in that most individuals do not frequently reflect on daily interactions with their environment. As a potential consequence of the pre-verbal nature of lived space, an emotion is often first experienced, which may reflect a sense of self in the space. Lived body is an individual’s understanding of his or her physical presence in the world. Lived body guides the researcher to a deeper understanding of the key stakeholders’ bodily experience of the world around them. Lived time is an individual’s biography. It is the past influencing the present and the future, as well as the present or the future influencing the past. Lived time guides the researcher to a fuller analysis of the key stakeholders’ biography, including the idea of transgenerational and historical trauma (Sotero, 2006). Lived other is an individual’s interaction with others or relationships that share space in his or her life. Lived other brings to the forefront interpersonal themes and projections that we make about others in our interactions with them. Lived other guides the researcher to uncover and make explicit key stakeholders’ lived experience of community trauma. These four reflection guides were used to capture an individual’s meaning behind the existential crisis caused by a trauma and the factors associated with an individual’s *lifeworld existentials* as they relate to potential barriers to treatment and help seeking processes.
Hermeneutics is defined as, “The study of the methodological principles of interpretation (as of the Bible) 2: a method or principle of interpretation” (Merriam-Webster Dictionary). Hermeneutics has its roots in biblical interpretation. The reader or interpreter of the text tries to make sense of what the author is trying to convey. The interpreter must understand the context and history associated with the text to interpret the text into a language understandable to the audience reading the text. Hans-Georg Gadamer states, “Understanding and interpretation are productive processes, a mediation between text and interpreter, a historical dialogue between past and present” (as cited in Packer, 2011). Text also can be an individual being interviewed, whereby the interpreter is the researcher. The goal of a hermeneutic study is interpreting the narrative of the interviewee or group’s insight into their history, social setting, and present situation. Using a hermeneutic phenomenological reflection method gave insight into the individual and group processes in relation to the phenomenon being investigated in this study.

**Research Design**

To aid in describing my research design, I have created a research design conceptual map (Figure 2). Concept mapping has been used in educational settings for many years to help clarify and guide research (Berg & Lune, 2012). My concept map includes four quadrants flanking an internal circle split into four parts. The first quadrant (upper left) identifies my primary and subsidiary questions this research seeks to address. The guiding question being explored in this study is: “How does community trauma affect social and individual recovery as well as the process of healing in a community programming context?” There are four subsidiary questions: (a) What is the lived experience of key stakeholders in an urban setting towards his/her lived time, lived space,
lived body, and lived relation (van Manen, 1990)? (b) What are the protective and risk factors involved in the help-seeking processes? (c) What factors may contribute to community and individual agency? (d) What potential mechanisms can be identified that can assist in community trauma abatement or prevention programming?

The second quadrant (upper right) indicates the qualitative methods used for the investigation. This study employed a multi-method analysis or Rapid Assessment Process (RAP). Included in the RAP is the consultative workshop an extension of focus groups, two-follow-up focus groups, PO, and PAR. In addition to this study using a multi-method approach, it is multi-layered as illustrated in the research design concept map (figure 2).

The third quadrant (Lower right) lists the main theoretical frameworks to guide the research. The theoretical frameworks include: Bioecological Model of Human Development (Bronfenbrenner, 1979, 2006), two motivational theories, Maslow’s Hierarchy of Needs (1970) and Ryan and Decci’s Self-Determination Theory (2000), social cognitive theory (Bandura, 2001), Historical Trauma Theory (Sotero, 2006), hermeneutic phenomenological reflection (van Manen, 1990), and narrative meaning making construction (Singer, 2004). The fourth quadrant (lower left) highlights what we know from the literature and what needs further investigation. The literature calls for more community-based research in racial/ethnic minority communities that can help identify the “malleable” barriers to treatment. The literature on potential barriers to mental health treatment is inconsistent (Hunt et al., 2013; McGuire et al, 2008; Kessler et al, 2005; Chow & Snowden, 2003).
Figure 2 Research Design Concept Map

**What**
1. Lived experience of community trauma
2. Identify protective and risk factors
3. Community-based research and application

**How**
1. Consultative Workshop Method
2. PAR
3. Participant observation

**Key issues (Why)**
1. Trauma-informed Community
2. Historical & transnational trauma
3. Attitudes/beliefs about seeking treatment
4. Social Justice

**Outcome**
1. Community driven behavior health
2. Trauma-informed community development strategy

**Review of the Literature**
- Need for community-based research
- Identifying "malleable" barriers that better explain racial disparities in current healthcare system
- Effects of trauma
- Stigma, racism, chronic community violence, social determinants, historical and transgenerational trauma
- Proximal and distal processes, identity formation, and resilience building.

**Primary question**
- How does community trauma affect social and individual recovery as well as the process of healing in a community programming context?

**Subsidiary questions**
- What is the lived experience of key stakeholder in the community?
- What are the protective and risk factors involved in the help-seeking processes?
- What factors may contribute to community and individual agency?
- What potential mechanism may assist in community trauma abatement or prevention programming?

**Qualitative methods**
- Multi-method analysis (RAP)
- Consultative workshop method, an extension of focus groups
- Participant observation
- Participant actions research (PAR)

**Theoretical framework**
- Biocological Model of Human Development
- Motivational Theories
- Social Cognitive Theory
- Historical Trauma theory
- Hermeneutic phenomenological reflection
- Narrative meaning making construction
The internal circle illustrates the what, how, why (key issues), and outcomes or application of my research. Each quadrant relates to an internal quadrant but is not limited to one quadrant, rather, it is circular, indicative of hermeneutic phenomenological investigations. Further, Berg and Lune (2013) state that there have historically been two theories of thought in relation to designing research. One theory posits a theory-before-research, and the other the opposite, a research-before-theory. These two models are linear in its progression, claiming each component is distinct and informs the others. In contrast, Berg and Lune present their own non-linear progression model. Their model spirals back forth between concepts, creating an integrated spiraling research design approach. This model includes the following components: Ideas→Literature Review (theory)→Design→Data Collection and Organization→Analysis and findings→dissemination (Figure 3).

**Figure 3 Spiraling Research Method (Berg and Lune, 2013, p. 25)**

This model asserts that a researcher never leaves behind any stage completely, but spirals back and forth leading to possible shifts or changes to the research question. My research design has adopted this model, as it best fits with the sensitivity and complexity
of my topic. To illustrate how I applied Berg and Lune’s spiraling research method to my research project, I have included my first research design concept map in Appendix A. There are significant differences between the first research concept map, which I created during the proposal stage of this study, and the model evolved during the collection and analysis of data. I made multiple revisions throughout the study, until the final concept map presented above in figure 2. For example, my questions became more refined and reflected more accurately what the community was seeking to understand more fully. In addition, the key issues and the “why” became more apparent adding depth to the research design and applied nature of the study. Further, Berg and Lune suggest novice researchers use multiple methods in a single investigation. In addition, using multiple theoretical perspectives, multiple data collection methods, and multiple analysis techniques increases triangulation and depth of a study (Denzin, 2010). The following paragraphs will highlight the multiple qualitative methods I used for this study.

Participants

Two types of sample strategies were used to conduct my research: purposive and snowball samples. Purposive samples and snowball sampling best illustrate the population being invited to participate in the consultative workshop (i.e., focus groups). Purposive samples are used when researchers have a special knowledge or expertise about a group and select individuals who represent the population under-study (Berg and Lune, 2012). In my case, the experts are the members of the FOCUS staff who selected key stakeholders for the consultative workshop. I chose not to use flyers to recruit key stakeholders for the study after consultation with FOCUS staff. Staff from FOCUS deemed flyers ineffective in this community and thought personal invitation the best
option for a successful consultative workshop. FOCUS staff identified 19 key stakeholders who attended the daylong consultative workshop on April 26, 2014. Key stakeholders were intentionally selected as a representative sample of the Hill community. Although the sample selection is purposive, it also shares a dimension with snowball sampling, because individuals who were initially invited by FOCUS were asked for referrals of others who share similar attributes as themselves (Burg & Lune, 2012).

Before the consultative workshop began I informed all the participants about my IRB approved study and the use of the study. All participants were informed of their right to participate, to refuse participation, or to remove themselves from the study at any time during the consultative workshop, and/or after the workshop is completed. Participants were informed that the purpose of the consultative workshop was not to disclose personal information but to address the questions proposed by the facilitators and other group members. Participants were informed that confidentiality is asked of all group members, but that it cannot be guaranteed. Each participant was provided with an “Informed Consent Form” that described the purpose of the study and use of the data. All participants signed the IRB approved informed consent form.

Pseudonyms were used for all participants in this study, except for Mr. Abernathy, who gave permission to use his real name for the study. Focus group 1 included eight members and one female facilitator (African American). The demographics included four males (three African Americans and one Eastern European) and three females (all African American) and ranged from 30 – 70 years of age. Pseudonym names for focus group 1 were Ms. Fuller, Ms. Carter, Mr. Cole, Mr. Marks, Ms. Moore, Mr. Jones, Mr. Abernathy, and Ms. Hart (facilitator). Note: Mr. Jones and
Mr. Marks only participated in the first focus group session. Focus group 2 included six members and one female facilitator (Caucasian). The demographics included three females (all African American), three males (All African American), and ranged in age from 20 -70 years of age. Pseudonym names for focus group 2 were Mr. Banks, Ms. Rogers, Ms. Tally, Ms. Heath, Mr. John, Mr. Mack, and Ms. Conner (facilitator). Focus group 3 included six members and one female facilitator (Caucasian). The demographics of the group included five females (all African American) and one male (Caucasian). Pseudonym names for focus group 3 were Ms. Mary, Ms. Holland, Ms. Green, Ms. Winter, Ms. Bell, Mr. Smith, and Ms. Edwards (facilitator). The participants included 11 African American females, six African American Males, and two Caucasian males. The sample is a good representation of the population and included community mental health professionals, longtime community members, clergy, political and social activists, community leaders and FOCUS Pittsburgh volunteers and staff (See Table 1 for demographics).

**Methods and Procedures**

**Rapid Assessment Process**

Rapid Assessment Process (RAP) has a strong documented track record for producing timely data that addresses public health problems. Rapid assessments have been used around the world, by such organizations as the World Health Organization (W.H.O.), United Nations (U.N.), and Doctors without Borders to study various public health issues. Needle et al. (2003) suggest that RAP is a preferred method when studying public health issues for the following reasons: (a) “collects locally relevant data about emerging patterns of risk behaviors and is relatively inexpensive.” (b) “Designed to
shorten the gap between research for specific programmatic purposes and the implementation of sound intervention strategies, emphasizing the adaptation of interventions to local cultures and conditions. (c) “Helps to address some of the distrust and resistance to participation in public health programs encountered in racial and ethnic minority communities, while also overcoming some of the problems of rapport building and cross-cultural applicability encountered when outsiders come into a community to do this type of assessment”(p. 970). RAP shares basic methodologies with ethnography, but are less costly and take much less time to gather data.

I used RAP to ground my research and add validity and reliability. Reliability and validity was maintained by triangulation of my findings by using multiple methods (Needles, et. al., 2003; Berg & Lune, 2012). The study utilized consultative workshop method an extension of focus groups, PO, and PAR. These methods produced quick intervention recommendations for the community. In addition, this study employed multiple theoretical frameworks. The data collected was summarized into a non-jargon fashion, making it accessible and easily understood by the community. I presented my results to the key stakeholders at the follow-up focus group gathering about a month after the initial data was generated through the consultative workshop, which I will explain later in this chapter.

**Consultative Workshop Method**

A consultative workshop is “a format for bringing together stakeholders, who are informed about and experienced in a particular area, for the purpose of problematizing a concern and addressing the specific problem or problem set” (Levers, 2003, p. 5). Consultative workshops provide pertinent information about a problem by experts in the
field related to the topic. After each plenary session, breakout focus group sessions occurred with key stakeholders from the community, who can apply new information, clarification related to lived experiences of participants, and work toward resolving problems. Levers (2003) defines the process as a pattern, where the presentation of expert knowledge—followed by small group application, followed by reconvened larger group discussion—may be repeated multiple times during the course of a single consultative workshop, thus making data generation and interpretation a highly iterative process (p. 6). I designed the consultative workshop in collaboration with FOCUS Pittsburgh staff/volunteers, and my dissertation chair. The day, time, and location for the consultative workshop were generated in collaboration with FOCUS staff/volunteers. For example, during the planning of the workshop, FOCUS staff and I were trying to figure out a location to accommodate all the participants, space flexibility and capacity for the plenary sessions, and the breakout focus groups. The FOCUS building was not big enough to accommodate the all-group sessions. We thought about using the local YMCA, but we ultimately decided upon a tent set-up on a vacant lot next to FOCUS. The rationale for the tent was strategic insofar as it would be immediately visible to the community. Community members who did not attend the workshop would ask, “What’s going on at FOCUS?” At which point community member would be informed about the topic of the consultative workshop. Having the workshop in a tent became a vehicle for “consciousness raising” for the community about community trauma. The following paragraphs describe the consultative workshop method I used in my study.

As stated above the consultative workshop was held on a vacant lot next to Focus in a tent on April 26, 2014. The consultative workshop was held on a Saturday from 10
am to approximately 4 pm. As participants arrived each key stakeholder received a nametag and folder, which included the following: IRB approved informed consent form, print outs of all PowerPoint presentations, illustration of Bronfenbrenner’s Bioecological Model of Human Development, notepad and pen, and agenda for the day. Also, I was intentional not to use any professional titles on the nametags (i.e., Ph.D. or Dr.) as a way to lessen potential divides associated with titles among key stakeholders, facilitators, and presenters. FOCUS provided lunch for all the participants at the workshop. See Appendix B for the full agenda of the consultative workshop. The consultative workshop brought together experts in the field related to community trauma, key stakeholders from the Hill District community for the purpose of problematizing community trauma and potential strategies to address community trauma. The goal of the consultative workshop was to generate rich naturalistic data by identifying pertinent information linked with phenomena associated with community trauma, such as underlying issues related to potential barriers to mental health treatment (Levers, 2003). For the consultative workshop 19 key stakeholders, four experts, and three facilitators for the focus groups attended the day-long event. I chose the three facilitators based on community knowledge and affiliation, or background in facilitating group discussions related to community trauma. The facilitator for focus group 1, Ms. Hart, is a doctoral student in the counselor education and supervision program, and a member of my cohort. “Ms. Hart” is a female African American student whose research agenda is focused on trauma and resilience of older African Americans in the community context. The facilitator of the second focus group, “Ms. Conner,” is a Masters level student in the counselor education and supervision program at Duquesne University as well. Ms. Conner, a Caucasian female,
has been engaged with the Hill District community for about four years in her capacity as a Campus Minister at Duquesne University. Ms. Conner has been involved with planning and implementing community engagement projects with Duquesne students and the Hill District community. The facilitator for focus group 3, “Ms. Edwards,” a female Caucasian, is the Clinical Administrator of the FOCUS Pittsburgh Free Health Center (FPFHC).

The format for the consultative workshop included four plenary sessions and three breakout focus groups after the first three plenary sessions, and a concluding all-group summary session, making data generation and interpretation a highly iterative and recursive process (Levers, 2003). For each of the three plenary sessions a ten to fifteen minute presentation on a specific topic was presented to all the participants. After each short plenary presentation participants attended their designated focus group. The FOCUS staff decided the selection of group membership in each of the three focus groups. I had FOCUS staff choose the make-up of the three focus groups, as they know more intimately the key stakeholders backgrounds and personality characteristics, creating dynamic and diverse opinions in each of the focus groups. In addition, having FOCUS staff choose the focus groups allowed for an interactional, free flowing, and increased the synergistic nature of the groups (Powel & Single, 1996). Focus group 1 included 7 individuals. Note: two participants left from focus group 1 after the first session. Focus groups 2 and 3 had 6 participants respectively. The three focus groups were held simultaneously and lasted about 40 minutes each. Each plenary session and focus groups were professionally videotaped and audio recorded for later content analysis.
Focus Group Protocol. The topic for the first session was an introduction to Bronfenbrenner’s Bioecological Model of Human Development (1979, 2006) as a framework for analyzing community trauma and identifying potential protective and risk factors associated with the help-seeking process. Dr. Levers started the first plenary session with an introduction to community trauma and the framework for the consultative workshop. After the introduction, another doctoral student from my Ph.D. program, with professional expertise in the area, presented Bronfenbrenner’s Model (see Appendix C for PowerPoint). Participants learned the importance of “proximal processes,” which are consistent, prolonged, and reciprocal interactions between the individual and his or her immediate environment. These proximal processes are the essential building blocks of development, contributing to an individual’s motivation, skill, knowledge, and ability to perform daily tasks and to build self-efficacy and resilience qualities. The Guiding questions asked during the first focus group session included:

- What is your response to what the speaker discussed?
- How does the information apply to the Hill?
- What are the protective factors involved in the help-seeking processes on the Microsystem, Exosystem, Macrosystem, and Chronosystem?
- What are the risk factors involved in the help-seeking processes on the Microsystem, Exosystem, Macrosystem, and Chronosystem?
- How do you think this needs to be addressed?

I was the presenter for second plenary session. The topic for the second session was exploring community trauma (see Appendix D for PowerPoint). I presented various definitions for trauma and community trauma, cultural perspectives, as well as a social
justice context relating to systemic issues of trauma. In addition, key stakeholders were informed about the potential effects from traumatic experiences, and more specifically the effects from chronic community violence. Guiding questions asked during the second breakout session included:

- What is your response to what the speaker discussed?
- How does the information apply to the Hill?
- How would you define “community trauma?”
- What may influence or perpetuate community trauma using the Bioecological map?
- Using the Bioecological map what are the assets of the community in relation to addressing community trauma?
- Using the Bioecological map what are the needs of this community in relation to addressing community trauma?

The third plenary session topic was information about the Adverse Childhood Experience (ACE) study (Felitti, et al., 1998). A graduate from my Ph.D. program an African American male who has worked in community mental health for over 10 years as a licensed professional counselor, presented the third session (see Appendix E for PowerPoint). Key stakeholders learned about the key finding of the ACE study, which has linked health risk behavior and disease in adulthood to exposure to emotional, physical, or sexual abuse, and household dysfunction during childhood. Guiding questions asked during the third breakout session included:

- What is your response to what the speaker discussed?
- How does the information apply to the Hill?
Using the Bioecological map what are the main problems with this in the Hill?

What are the attitudes towards mental health? Treatment?

Using the Bioecological map, what may influence these attitudes?

Using the Bioecological map, what are potential barriers to treatment?

The final “wrap-up” session of the consultative workshop concluded the daylong event. Dr. Levers presented a short PowerPoint presentation on how to frame the day’s workshop, including Herman’s (1992/1997) three stages of trauma recovery, and facilitated a group conversation about how the community can begin to heal and plan community-based programing (see Appendix F for PowerPoint). Each of the three facilitators presented to the whole group a synthesis of relevant naturalistic data generated from each focus group session. In addition, all notes from large newsprint generated from the focus groups were hung on the walls of the tent for all participants to see and speak from (see Appendix G for pictures).

The consultative workshop meets the four characteristics needed for a legitimate systematic inquiry (Levers, 2003). The four characteristics are: (a) “The data must be naturalistic,” meaning, the data must come from those directly affected or work closely with population being studied. (b) “The project must be designed intentionally, with both pedagogical and research outcomes in mind.” For the process to meet the criteria as a Consultative Workshop Method, research outcomes must be “planned, deliberate, and intentional.” (c) The nature of the research process must be “iterative and recursive.” (d) Similar to RAP, the data collection process leads to immediate feedback to participants (p. 24). The consultative workshops provided fertile ground for identifying relevant
information about the developing phenomenon associated with community trauma and key stakeholders planning emergent community-based services.

The consultative workshop generated rich naturalistic data by identifying pertinent information about emerging phenomena, such as underlying issues attached to potential barriers to mental health treatment and factors related to community trauma. In addition, this method is most appropriate for this community in that it fosters a collaborative approach. The Hill has a predominantly African-American population, where historical mistrust and distrust of researchers and the medical field is a widely held belief. The method is horizontal and similar to PAR and RAP, helping to ease mistrust, and build rapport. Instead of a traditional hierarchical approach to research, the consultative workshop method is mutually beneficial to the academy and the community. The next section will more fully describe the focus group method, as it is an extension of the consultative workshop method.

**Focus Groups**

The consultative workshop method is an extension of focus groups (Levers, 2003). As described earlier in this section, the consultative workshop utilized three focus groups, which met after each of the plenary sessions. The focus groups met for approximately 40 minutes for each session. Each focus group met three times and the whole group met for the summary session as one large focus group. The consultative workshop method allowed for ten focus groups to be conducted in one day and four plenary sessions, providing approximately 7.5 hours of video-recorded data collectively.

Powel and Single (1996) posit that a focus group methodology can generate rich divergent data pertinent to researching health care provisions, where quantitative and
other qualitative techniques fall short. Focus groups help generate, “in-depth understandings of perceptions, opinions, and the ways in which people make meaning of a variety of aspects of life” (Levers, 2006, p. 381). I prepared guided questions for the facilitators, articulated earlier in the chapter for each of the focus groups based off the plenary session topics. The guided questions helped to generate "the rich details of complex experiences and the reasoning behind [an individual's] actions, beliefs, perceptions and attitudes" (Powel & Single, 1996, pp. 499-500). I choose to use facilitators for each of the focus groups to allow more time for PO and managing the consultative workshop as a whole. Each focus group also had a large poster size illustration of Bronfenbrenner’s Bioecological Model of Human Development taped to the wall. Each facilitator was given large newsprint, post-it notes, and markers for taking notes. Facilitators and participants were encouraged to write relevant information on post-it notes and place the thought on the poster of the Bioecological Model on the related system (see Appendix H for example).

Further, I chose focus groups to help increase morale and generate feelings of self-worth among participants, as well as to express to the participants a sense of “listening” and being heard. Powel and Single (1996) suggest four areas where focus groups can be beneficial to research: (a) “existing knowledge is inadequate…or the generation of new hypotheses is necessary before a relevant and valid questionnaire can be constructed or an existing one enhanced;” (b) “the subject under investigation is complex and concurrent use of additional data collection method is required to ensure validity;” (c) “The subject under investigation is complex and comprises a number of variables. A focus group enables the researcher to concentrate time and resources on the
study’s most pertinent variables;” and (d) “The results of a quantitative survey are ambiguous or misleading and statistical associations require clarification, elaboration, or ‘salvaging’” (p. 500). My research study fits within the four areas that benefit from using focus groups.

There are advantages in using focus groups in comparison to in-depth interviews and nominal group techniques. In-depth interviews are “one-to-one research technique in which a respondent answers a researcher’s questions…pursues a respondent’s subjective interpretation of a subject following a loosely structured or unstructured interview guide” (Powel & Single, 1996, pp. 502-503). Powel and Single contend that synergy and open-ended dialogue fostered by a focus group methodology helps the researcher “identify quickly the full range of perspectives help by respondents” (p. 504). Further, focus groups have the potential to provide entry to both actual and existentially meaningful or pertinent interactional experiences (Berg and Lune, 2012). Berg and Lune (2012) identify eight advantages to using focus groups for qualitative reach:

1. The focus group is highly flexible (in terms of number of participants, groups, costs, duration, etc.).
2. It permits the gathering of a large amount of information from potentially large groups of people in relatively short periods of time.
3. It can generate important insights into topics that previously were not well understood.
4. It allows researchers to better understand how members of a group arrive at, or alter, their conclusions about some topic or issue and provide access to interactionary clues.
5. It can be used to gather information from transient populations.

6. It places participants on a more even footing with each other and the investigator.

7. The moderator can explore related but unanticipated topics as they arise in the course of the group’s discussion.

8. Focus groups do not usually require complex sampling strategies (p. 172).

Using a focus group methodology in examining community mental health and community trauma in the Hill has shed light on the complexity of problems. The focus groups created a space for open interactional dialogue. This open dialogue helped the researcher generate, "the rich details of complex experiences and the reasoning behind [an individual's or communities] actions, beliefs, perceptions and attitudes" (Powel & Single, 1996, pp. 499-500). The next method I used for my study was PO.

**Participant Observation**

Glesne (2011) asserts that participant observation (PO) is on a continuum, ranging from mostly observation to mostly participation. She cites 4 points on the continuum, which include “observer, observer as participant, participant as observer, and full participant” (p. 64). I would classify my participation as “participant as observer.” I first became involved with FOCUS Pittsburgh three years ago. I was invited by Duquesne University’s Center for Catholic Intellectual Tradition and the Center for Community Engaged Teaching and Research to help plan and be a part of a deliberative dialogue exploring the idea of community trauma in the Hill District. During the planning, I met the Director and staff of FOCUS Pittsburgh. Since January 2013, I have volunteered at FOCUS, participated in community events, planning committees, facilitated trainings,
and just “hung out” at FOCUS. I have spent over 300 hundred hours at FOCUS or in the Hill community over the last three years. In addition, since the FOCUS Pittsburgh Free Health Center (FPFHC) opened in the summer of 2014, I have been providing pro bono counseling to patients at the health center. Prior to engaging in this project, I was a full time Campus Minister at a local University for 12 years, where I was engaged in various projects with the Hill community and university students.

The process of PO is different than observing people and interactions in everyday, in that PO is goal orientated, requiring careful observations and detailed record keeping. I kept multiple journals throughout the study. I used these journals to make descriptive and jotted notes about my interactions and observations about the community and interactions at FOCUS (Glesne, 2011). I also created analytic notes from my jotted and descriptive notes as a way of tracking my feelings, ideas, impressions, working out of problems, speculations about what was happening, and to understand the patterns and themes in my research. I used Glesne’s approach to field notes to guide my observations and reflections. Glesne states, “Participant observer must constantly analyze his or her assumptions for meaning (What is going on here?) and for evidence of personal bias (Am I seeing what I hoped to see and nothing else? Am I being judgmental and evaluative?)” (p. 68). In addition, Glesne offers three guiding questions: “what surprised you?” (helps to track assumptions); “What intrigues you?” (helps to track personal interests and positions); and “What disturbs you?” (helps to track tensions and possibly stereotypes and prejudices) (p. 77).

During the consultative workshop and each of the focus group breakout sessions, I took notes to record my thoughts, reflections, key observations, casual interactions and
side conversations with participants, and individuals who were not participants at the consultative workshop, but hanging around FOCUS. The individuals hanging around FOCUS were there for lunch and/or curious as to what was happening at FOCUS. After the consultative workshop, I gathered all of my reflections, notes, and observations, and wrote a reflective memos with pertinent information and observation from the consultative workshop.

The participant observer’s role is dependent on the researcher and the researched. Horowitz sates:

I will argue that fieldwork roles are not matters dictated solely, or even largely, by the stance of the fieldworker, but are instead better viewed as interactional matters based on processes of continuing negotiation between the researcher and the researched. Together, the qualities and attributes of the fieldworker interact with those of the setting and its members to shape, if not create, an emergent role for the researcher (as cited in Glesne, 2011, p. 93).

The above quote describes my role development since the research project developed over three years ago and the formal study began with IRB approval in March 2014. I have been welcomed into the “FOCUS family,” and integrally involved with planning and implementing community driven behavior health initiatives, as a result of the consultative workshop. Although I have grown close to the individuals at FOCUS, I am still an “outsider” in the community. But I am an outsider trying to facilitate authentic collaboration between a racial/ethnic minority community and the academy, through community-engaged research.
**Participant Action Research**

A consultative workshop method is linked to (PAR) or action research (AR) by intentionally using tenets of the PAR in the construction of the workshop (Levers, 2003). The consultative workshop was constructed with an emphasis on authentic participation from key stakeholders and the lived experience of community members. The consultative workshop was intentionally designed to bring together professionals in the field of trauma and recovery with “experts” in the community to create a shared knowledge base and synthesis of the information shared for the purpose of creating community-based services. This approach leads to a “horizontal rather than vertical pedagogical model, one that intentionally was designed as not hierarchical” (Levers, 2003, p.22).

Young people of the 1990s, such as college students and/or persons of faith, were beginning to be asked to volunteer and to get involved with the marginalized, poor, and disempowered in the United States. Unlike the “Me Generation” of the 1980s, the 1990s this generation promised to be the “Thee Generation.” Universities began requiring students to complete a service requirement prior to graduation and student projects that engage with poor populations surrounding university campuses have started to receive funding as well as support from administrations and alumni. Many academic institutions now have service learning or community engagement requirements in addition to their traditional classroom learning. My study utilizes the three common components of participatory research. These components include: (a) “a commitment to the needs and interests of the community;” (b) engaging with the community so that its voice defines the problems and goals; and (c) “a moral commitment to the transformation of social, political and economic injustices directly afflicting the community studied” (Petras &
Porpora, 1993, p. 108). These three components are found in the consultative workshop method. Further, PAR “can be understood as a means or model for enacting local, action oriented approaches to specific problems in a particular situation” (Berg and Lune, 2012, p. 260). My research design and study from the beginning was collaborative, intentional, and action-orientated to attempt to address issues related to community trauma. In addition, the University of Central America model (UCA) offers an example of PAR that shares similar characteristics with my study, highlighting the relationship between the academic institution and the community.

The UCA model “directly involves community members in collaboration with a network of academics” (Petras & Porpora, p. 111). This model was developed at the University of Central America in San Salvador, El Salvador, where six Jesuit priests and two women co-workers were murdered during the Salvadoran Civil War. This model challenges not only how knowledge is produced, but what the focus of the university should be. This model notes that the “proper object of the university’s attention is the national reality” (p. 116). What this means is that if the majority of Salvadorans can barely satisfy their human needs, then they are surely not realizing their full human potential. The same could be said for many in the Hill District. Therefore, the UCA model seeks to discover the structures and arrangements that allow inequality and injustice to continue. The UCA model also proposes that while the university has academic knowledge, the knowledge that comes from the people living the national reality must be privileged. Their knowledge can also produce their solutions. Consequently, the university seeks to be part of the solution as opposed to part of the problem. PAR seeks to make the research mutually beneficial for academic institutions
and the population being researched. This is particularly important in the Hill, where historically this population has been deceived in social and medical research. For this reason PAR is most appropriate for my research design.

Further, Berg and Lune (2012) suggest a four-stage process for PAR called, “The Action Research Spiral Process,” which I used for my study (See figure 4). The four-stages are: (a) “identifying the research question(s); (b) gathering the information to answer the question(s); (c) analyzing and interpreting the information; and (d) sharing the results with the participants” (p. 264). Figure 4 is an illustration of the “The Action Research Spiral Process” by Burg and Lune (2012, p. 264).

**Figure 4 The Action Research Spiral Process**

The following describes my use of Berg and Lune’s four-stage process. One, after spending time in the community, participating in community dialogues on community trauma, and being a part of the planning of the FPFHC, I was able to collaborately identify the guiding question and subsidiary questions discussed early in the chapter for my study. Two, the primary data collection or “gathering of information to answer my research questions was the consultative workshop held on April of 2014. Three, the data from the consultative workshop (e.g., focus groups, participant observation) was analyzed
and interpreted. Last, I shared the results with the participants at the follow-up focus group on June 12, 2014. These preliminary results also help shape the initial vision for a community driven behavior approach to address community trauma presented on June 12, 2014. A more detailed description of results and action plan generate from the data collected will be described and discussed in chapters 4 and 5.

**Instruments**

In qualitative research, the researcher is the instrument used for analyzing the data collected (Berg & Lune, 2012; Glesne, 2011). Being that the researcher is the instrument for qualitative research, much responsibility and transparency is warranted from the researcher, as well as an ethical integrity in relation to the population being investigated. What qualifies the researcher, a White male from Southern California, to take on a study such as this? For over the past 10 years, I have planned and facilitated 7-10 days cross/cultural mission experiences domestically and internationally for college-age students. The experiences provided opportunities to learn, live, and work “with” and “in” ethnic/racial minority communities experiencing low SES status. I have worked for many years in the Hill District with residents and Duquesne University students, faculty and staff. My primary work with the Hill encompasses community engagement, focusing on social justice issues, and nonviolent social change. In addition, I was invited by the only historically black fraternity on Duquesne University’s campus to be their advisor. I have been the advisor for this fraternity for the past three years. Beginning in the summer of 2013, I was involved with the FPFHC planning committee for which this study was derived. At the same time, I recognize my own White privilege (WP) and how I may be
perceived as a researcher in the community. A brief discussion about WP is warranted here.

WP is clarified as the institutionalized privilege “based in White Ethnocentric definitions of self and others, good and evil, right and wrong, normal and abnormal” (Neville, Worthington, & Spanierman, 2001, p. 264). Western White society sees the world through the lens of their own existence, which we can see through common expressions used in society. For examples, “the pot calling the kettle Black” or “this was a dark day in our history, or the association of darkness with economic or societal depression (Neville, et al., 2001, p. 264). The use of color in our analogies points to the lens through which Whites view their identity and associate it with the good and with the “normal.” The use of the above expressions and the understanding of self in this context permits racism under the guise of what is “normal” instead of the privileges associated with Whiteness. In psychology and counseling, the focus as been on the disadvantaged in terms of micro and macro racism, but one cannot fully uncover the truth of racism as a White person without first understanding their advantages and benefits from a system of racial oppression (Neville, et al., p. 260). When I reflect on my WP and my research study in the Hill, I am reminded each time I leave FOCUS, when I get in my car and drive across the river to my home. As a researcher I will never really know what it is to live day-to-day in the Hill or as a Black male. My experiences in the Hill are short and at the end of the day I go back to my less diversified urban neighborhood. The following is an analytic reflection memo I wrote after I facilitated a training at FOCUS on April 9, 2014. I had a profound experience on the way home from the meeting that is applicable to this brief discussion about my WP and how African Americans may view me.
I had just finished with facilitating a training at FOCUS and heading home for the evening, but I needed to stop for gas on the way. To get to my house from FOCUS I have to cross a river, which not only creates a topographical divide between where I live and the residents of the Hill, but a racial and economic divide as well. I stopped at a local gas station in my neighborhood. I was tired from a long day and just wanted to fill the car up with gas, go home to see my family, and have dinner. As I was pumping the gas into my car, I noticed an African American male coming my way. He had just finished talking to the person in the pump station in front of me. I thought to myself, “oh come on, I am not in the mood to hear a story and be asked for money.” The male came up to me with two pieces of paper in hand, and began to tell me he was just released from jail, the judge was lenient of him, and he needed some money to get home on the bus. He needed $16. I thought to myself, “This is a very expensive bus fair.” He is showing me the papers from the judge as proof. I briefly glance at them, but do not really look at them clearly, as my mind is already thinking about how to get him away as quickly as possible and not giving him all the money in my wallet. He is pleading with me to help him. He has a slight quiver and slur in his voice. I tell him I only have $5 and take out my wallet. I actually have $11 dollars in my wallet, which he sees. He proceeds to tell me “we are not all bad.” I think I mumbled something, but I find myself searching for words, but not much is coming out. My mind is racing with the years I worked with the homeless populations, my job as a Campus Minister and countless years of social justice work. I am thinking, “You don’t know me” or “what I do for a living.” I just came
from doing a training in the Hill. You think I am another White male who thinks you are a “bad person,” because you are Black and asking me for help. I had a moral and ethical battle raging in my head. If this were 15 years ago, I would have given him the money with no hesitation, but now I am less naïve and maybe a little more skeptical. He keeps looking at me and saying, “We are not all bad.” Again, I can say nothing in reply. I only stare back as if frozen and watching myself. I give him the $11 in my wallet, he takes the money and begins to walk away, but then he turns around and comes back to me and kisses me on my cheek saying, “We are not all bad.” He turns around and leaves.

Upon reflection, I immediately thought about this Sunday being Palm Sunday. What did this encounter mean? Why did he keep saying “we are not all bad,” and kissed me on my cheek? Is there a passion story playing out in real time for me. If so, who is Jesus, who is Judas or Pilate or the other disciples? Why was I so against engaging this guy? Why did I feel that I needed to let him know of my work, that I didn’t think he was a bad person, but I couldn’t say anything? I wonder how individuals at FOCUS view me? What is unconscious in me that may have surfaced in me during this encounter? This encounter makes me reflect on the lived existentials from a new perspective that not only includes the gentleman I encountered, but my own in relation to him. (Analytic reflection memo, April 2014)

I think what strikes me about this encounter and my reflection is that I didn’t engage him in conversation. I was frozen in my own body, which was not like me. I think this experience points to the lived reality of my lived existentials, that somehow because of
my previous work experiences and my work in the Hill, the glow of my WP had been miraculously dulled and others would not be able see it. The richness of this encounter illustrates in many ways the deep seated divide or lived reality between the “White” and “Black” lived existentials (van Manen, 1990). To be aware of my male WP and my work with populations who have been marginalized (denotes my privileged position), does not necessarily change the inequality that exists, but can in fact maintain the already entrenched power systems of the majority. My silence and feeling somewhat frozen or maybe fearful in my encounter with the African American male described above, illustrates to some extent, the historical “White” socialization or residuals from the American Chattel slavery that still may dwell within me. Unless, collaboratively the systems as a whole are changed systemically on the social, political, physical, and economic. Doing qualitative research requires in many respects is a dialectic, to make the tension explicit between two different lived realities in an attempt to make the research more authentic.

Being a good qualitative researcher calls for continual self-reflection about my own assumptions or biases as the research evolves, such as the analytical reflection memo above, and how it may influence the research. Bracketing is a term used in phenomenological inquiry and is applicable here. Bracketing is an intentional process where the researcher removes his or her biases and explains the phenomenon in terms of its own intrinsic system of meaning (Newsome, Hays, & Christensen, 2008). Along with my work in the Hill, my research agenda has revolved around trauma and the concept of Posttraumatic Growth. Finally, I am a professional counselor who works with racial/ethnic minority individuals as a therapist.
Data Collection and Recording

The primary method for collecting my data was from the consultative workshop held on April 26, 2014. A tent was used for the plenary and all group sessions of the consultative workshop. The tent was erected on a vacant lot next to FOCUS. Prior to the consultative event, FOCUS volunteers built a stage out of recycled wood pallets and plywood. Inside the tent was the stage used for presentations and housed all the AV equipment, including a sound system, projector for PowerPoint presentation, and video screen. Three rows of tables and chairs were set up facing the stage, allowing participants to more easily take notes and a place to eat lunch. The breakout focus groups were held inside FOCUS Pittsburgh. All groups met on the second floor of the building. Focus group 1 used the FPFHC exam room. Focus group two met in an adjoining administrative office. Focus group 3 met in a small back room that doubles as a community computer lab.

A professional audio/video technician was used to set-up and record all the plenary, focus groups sessions, as well as the summary session from the consultative workshop. Three video cameras were used as the three focus groups were held simultaneously. Also, three back-up audio recorders were used in all of the focus group sessions in case of video camera malfunction. In addition to all focus group recordings, each focus group had a facilitator who took notes on large newsprint and presented major points during the summary session. Further, each focus group had a large poster size illustration of the Bioecological Model where participants and facilitator could write on post-it notes any pertinent information and stick it to the corresponding system on the Model. Early in this chapter I described in detail the daylong consultative workshop held
on April, 2014, under the “consultative workshop method section.” In addition to the consultative workshop, I also video-recorded the follow-up focus group meeting held on June 12, 2014. The data I collected came from the focus group video recordings, newsprints, Bioecological Models with post-it notes, plenary session presentations, observations, informal meetings, community group meetings, and memos generated from my experience in the Hill District and at FOCUS.

Data Analysis

For this study, I used a RAP strategy that included the consultative workshop method, focus groups, PAR, and PO. In essence, the consultative workshop method encompassed focus groups, PAR, and PO (Levers, 2003). I utilized Berg and Lune’s (2012) Action Research Spiral Process to guide my research study. I grounded my research in three main theories (see Chapter 2): (a) van Manen’s (1990) Hermeneutic Phenomenological Reflection as a mode for conducting thematic analysis. The use of this approach is most appropriate in trying to understand meaning (phenomenological themes) behind the lived experience of community trauma. (b) The Bioecological Model of Human Development to more fully understand the complex interplay multiple-systems or environments can have on a child’s development, as well as individuals throughout the lifespan (Bronfenbrenner, 1979, 2006). In addition, the Bioecological Model puts an emphasis on the relationship between heredity and environment making it compatible with historical trauma theory (Atkinson, Nelson, & Atkinson, 2010; Sotero, 2006) and Posttraumatic Slave Syndrome (DeGruy, 2005). And (c) Historical trauma theory that provides a macro-level observation of how the life experiences of a population exposed to trauma at a certain point in time (i.e., slavery) relates to an unexposed future.
generation (Sotero, 2006). The following paragraph will describe my data collection process.

All raw data collected from videotaping the focus groups, consultative workshop, were transcribed in part to generate themes using content analysis. I was a PO during the entire consultative workshop and focus groups, taking notes on discussions, and identifying trends and patterns that reappeared during the focus groups. Content analysis was conducted on all transcriptions, video, and print material collected during the consultative workshop and follow-up focus groups. Berg and Lune (2012) define content analysis as “a careful, detailed, systematic examination and interpretation of a particular body of material in an effort to identify patterns, themes, biases, and meanings” (p. 349). This method of analysis is most appropriate for my study, as I sought to further understand the phenomenon associated with key stakeholders’ experience of community trauma and planning processes for healing through community-based services.

To begin my content analysis, I used “open coding,” as this allows for the novice researcher not to be overwhelmed by the data and open the inquiry broadly (Berg and Lune, 2012; Strauss, 1987). My research method is action-oriented, therefore collaborative, and requires that I present my preliminary findings to the key stakeholders in a relatively quick timeframe. It was agreed between the key stakeholders and myself we would have a follow-up focus group in about a month from the consultative workshop. After the consultative workshop I watched all video recordings from the consultative workshop in their entirety to get accustomed with the data. I watched all the videos one time through and then watched them again, this time excerpting quotations related to the questions from each of the consultative workshop breakout focus group
sessions. I grouped all of the quotations and themes that emerged from focus groups 1, 2, and 3 and classified them under each of the questions asked from session 1. I repeated this process for sessions 2 and 3. I initially wrote out pertinent quotes and emerging themes on paper than transcribed them into word documents, titling each focus group according to name and session, for example, “focus group 1 session 1.” In addition, I placed quotes and themes under the specific questions asked from the consultative workshop focus group protocol to help organize the data, which I described earlier in this chapter. After I grouped quotes under each of the questions asked in the focus groups, I went through the data again and began to code the major themes that emerged and began to relate those themes to the literature. For example, stigma is reported to be a potential barrier to the help seeking process for ethnic/racial minority groups that may contribute to disparities in the behavior healthcare system. From the initial coding of the data, I began to interpret the emerging themes and organize them in a word document using non-jargon wording to be presented to the key stakeholders at the June 12, 2014 follow-up focus group gathering. During the month between the consultative workshop and the follow-up focus group meeting, I was meeting with Focus staff and volunteers to formulate an initial vision for an intervention strategy for the community based on the consultative workshop findings. I presented my preliminary results to the key stakeholders at the follow-up meeting, which primarily at this stage in the analysis focused on barriers to treatment. In addition, an initial “Bio-ecological care plan” vision was presented to the key stakeholder and feedback was solicited from the group (see appendix I for handout of proposed vision and initial data findings). I video-recorded the follow-up focus group meeting for later analysis.
From the follow-up focus group meeting, I worked collaboratively with FOCUS in refining the Bioecological care plan vision based on feedback from the focus group, analysis from the data, and empirical literature related to community trauma and potential interventions. In September 2014 we had a second follow-up focus group meeting with the key stakeholders from the consultative workshop and presented a revised version of the vision called, “trauma-informed community development strategy.” (see Appendix J for revised trauma-informed community development strategy). From the second follow-up session a planning committee was established. Bi-weekly meetings were held to further refine the trauma-informed development strategy for the purpose of employing the strategy in about one year. The planning committee included five individuals who participated in the consultative workshop, including myself, as well as Mr. Lawson (pseudonym) who attended the first follow-up focus group, and two interns from FOCUS. All the bi-weekly meetings were audio recorded and notes were taken during every meeting and included in the overall analysis.

After the June 12, 2014 focus group gathering, I had more time to be more systematic in my approach to coding factors and emerging themes from my data. To aid in this process, I purchased Atlas.ti, a qualitative code-based theory builder with the ability to analyze textual descriptions and video. I purchased Atlas.ti to help organize my data and more systematically code the various forms of data I have collected. The use of computer software to assist in the analysis of qualitative textual data has been around for over 50 years. Using a qualitative software package allowed for versatility, storage, organizing, coding, and creating conceptual networks. I imported all the recorded videos from the consultative workshop and follow-up focus group meetings into the Atlas.ti
program. In addition, I imported all of my word documents used for my initial analysis of the consultative workshop and presented at the June 12, 2014 meeting. I watched again all of focus group recordings including follow-up focus group meeting in *Atlas.ti*. I used a combination of inductive and deductive content analysis (Straus, 1987). First, I used an inductive approach where I immersed myself in the texts (i.e., video, field notes) in order to identify emerging themes from text that were meaningful to generate a theoretical framework (Berg and Lune, 2012). Second, I used a deductive approach where I drew from van Manen’s (1990) Hermeneutical phenomenological reflection framework in an attempt to make explicit the *lived Existentials* of key stakeholders’ experience of community trauma and planning of emerging community-based services. In addition, I drew from Bronfenbrenner’s (1979, 2006) Bioecological Model, and historical trauma theory (Sotero, 2006) to help frame my hypothesis in relation to my research questions.

In *Atlas.ti* I coded directly from the focus group video recordings. In Atlas.ti each study or project is bundled in what is called a hermeneutic Unit (HU). Included in the HU are all the audio/video recordings, associated journal articles, field notes, memos, and my initial data analysis done in word documents. To illustrate my focus group video-recorded coding in *Atlas.ti*, I took a screen shot from my project in *Atlas.ti* (See figure 5).

**Figure 5 Atlas.ti Screen Shot**
The screen shot illustrates my direct coding from the video of focus group 1 session 2. On the left hand side of the screen shows a partial list of the all imported documents in my HU. On the ride side are comments, direct transcriptions of the conversation, and underneath the comment window is related codes.

During my original open coding I had generated 67 different codes (see Appendix K for code book). From the 67 codes, review of the literature, patterns of emerging themes related to my research questions became more apparent. Through this process five main themes arose: stigma, social determinants, racism, chronic community violence, and transgenerational or historical trauma. These five main themes are presented in Chapters 4 and 5. From these five main themes I create code groups. The code groups included: agency/vacant esteem, ecological factors, community-based services, lived existentials (i.e., lived body, lived time, lived other, and lived body), identity, and the five main themes already reported. The 67 codes I originally coded were then grouped in the above 10 categories (see Appendix L for list of codes associated with groups). I color-coded the 10 categories for ease of organizing my data. In addition to the thematic coding, Atlas.ti has a network function, which I used to help diagram and interpret my data. The network function utilizes your codes and helps the researchers show connections and relationships between thematic codes creating a conceptual map and build theory (see Appendix M for network map). It is also important to note that during my analysis of my data, I was continuously involved with FOCUS and their planning of the trauma-informed community development strategy. This back and forth between the content analysis and participation with key stakeholders was in a sense “living the questions,” my research study was exploring. This was evident in that my participation with key stakeholders
continually influenced my interpretation of the phenomenon under study, as well as my research was influencing the development of the community-based services. In other words, “discovery proceeds by a see-saw of analysis and integration similar to that by which our understanding of a comprehensive entity is progressively deepened” (Polanyi, 1961, p. 464). Further, my research design, data collection, and analysis illustrate an authentic collaboration between the participants (i.e., key stakeholders) and myself that took place during the study from the beginning to the end of the study.

Summary

This qualitative study used a hermeneutic phenomenological reflection approach to gain insight into phenomena associated with the lived experiences of Hill District key stakeholders’ experience of community trauma and potential barriers to healing and recovery. A phenomenological reflection approach offers a systematic way to imagine, reflect, and analyze data to produce rich text and insight. My research method design used Berg and Lune’s (2012) spiraling research method. My research method design is circular, intentionally horizontal in nature, and compatible with a multi-method approach. This chapter outlined my multiple-method qualitative approach, which increased depth and triangulation. The multi-method analysis or RAP included a consultative workshop method, an extension of focus groups, two-follow-up focus groups, PO, and PAR. A multi-methods design allowed for flexibility as well as for multiple angles from which to view, interpret, and analyze the phenomenon under study. Finally this chapter described my data collection and recording procedures.
Chapter 4: Findings

Introduction

This chapter presents an in-depth explanation of my major findings and the themes that have been generated from my research project. I provide the demographic characteristics of participants and a description of the recruitment process. In addition, I provide an analysis of each of the three focus groups for each session of the consultative workshop as well the two follow-up focus group gatherings for a total of 11 focus groups. The guiding question for my research project: “How does community trauma affect social as well as individual recovery and the process of recovery in the community context?” My subsidiary questions include: (a) “What is the lived experience of key stakeholders in an urban setting towards his/her lived time, lived space, lived body, and lived relation” (van Manen, 1990). (b) “What are the protective and risk factors involved in the help-seeking processes?” (c) “What factors may contribute to community and individual agency?” (d) “What potential mechanisms can be identified that can assist in community trauma abatement or prevention programming?” These guiding questions informed the design of the consultative workshop, a form of Rapid Assessment Process (RAP), held in April 26, 2014 at FOCUS Pittsburgh. The consultative workshop brought together key stakeholders from the Hill community to explore community trauma and begin planning emergent community-based services. The consultative workshop generated rich naturalistic data by identifying pertinent information linked with phenomena associated with community trauma, such as underlying issues related to potential barriers to mental health treatment.
The material from the data is related to specific features from the theoretical framework for this study, as presented in Chapter 2. I present my exploratory research findings, which suggest five main contributing risk factors or themes influencing community trauma in the Hill District and the help-seeking process. The five risk factors are stigma, chronic community violence, social determinants, racism, and transgenerational or historical trauma (Sotero, 2006; Heart & DeBruyn, 1998). I will present the protective factors identified from the focus groups, which included community non-profit organizations, historical resilience of African Americans, and spirituality/religious affiliation or belief. In addition to identifying the protective and risk factors using Bronfenbrenner’s Bioecological Model for Human Development, I used van Manen’s (1990) Lifeworld Existentials to generate thematic analysis of the focus groups, in an attempt to make explicit the lived experience of key stakeholders’ experience of community trauma and planning emergent community-based services. Finally, I will present the process and results of the planning process of the applied research findings for the development of a community driven behavioral health approach to change and healing in the community.

Recruitment of Participants

Two types of sample strategies were used to conduct my research: purposive and snowball samples. Purposive samples and snowball sampling best illustrate the population being invited to participate in the consultative workshop (i.e., focus groups). Purposive samples are used when researchers have a special knowledge or expertise in some group and select individuals who represent the population under-study (Berg and Lune, 2012). In my case, the experts are the members of the FOCUS staff who will select
key stakeholders for the consultative workshop. The researcher chose not to use flyers to recruit key stakeholders for the study after consultation with FOCUS staff who deemed flyers ineffective in this community and personal invitation the best option for a successful consultative workshop. FOCUS staff identified 19 key stakeholders who attended the daylong consultative workshop on April 26, 2014. Key stakeholders were intentionally selected as a representative sample of the Hill community. Although, the sample selection is purposive, it also shares a dimension with snowball sampling, because individuals who were initially invited by FOCUS were asked for referrals of others who share similar attributes as themselves (Burg & Lune, 2012). The consultative workshop, an extension of a focus group, was held at FOCUS Pittsburgh on April 26, 2014. The break out focus group sessions were held inside FOCUS and a tent was set-up outside on a vacant lot next to FOCUS’ building to accommodate the all participant sessions and group presentations.

**Demographic Details**

Pseudonyms were used for all participants in this study, except for Mr. Abernathy, who gave permission to use his real name for the study. Focus group 1 included eight members and one female facilitator (African American). The demographics included four males (three African Americans and one Eastern European) and three females (all African American) and ranged from 30 – 70 years of age (see table 1). Pseudonyms names for focus group 1 were Ms. Fuller, Ms. Carter, Mr. Cole, Mr. Marks, Ms. Moore, Mr. Jones, Mr. Abernathy, and Ms. Hart (facilitator). Note: Mr. Jones and Mr. Marks only participated in the first focus group session. Focus group 2 included six members and one female facilitator (Caucasian). The demographics included three females (all
African American), three males (All African American), and ranged in age from 20 -70 years of age. Pseudonyms names for focus group 2 were Mr. Banks, Ms. Rogers, Ms. Tally, Ms. Heath, Mr. John, Mr. Mack, and Ms. Conner (facilitator). Focus group 3 included six members and one female facilitator (Caucasian). The demographics of the group included five females (all African American) and one male (Caucasian).

Pseudonyms names for focus group 3 were Ms. Mary, Ms. Holland, Ms. Green, Ms. Winter, Ms. Bell, Mr. Smith, and Ms. Edwards (facilitator). The table below list participants’ demographics by focus group, age range, years of involvement at FOCUS Pittsburgh and paraprofessional/community affiliation.

**Participant Demographics and Paraprofessional/Community Affiliation By Focus**

### Group (Table 1)

<table>
<thead>
<tr>
<th>Participant (Pseudonym) &amp; Focus Group #</th>
<th>Male/ female</th>
<th>Age Range</th>
<th>Race/ ethnicity</th>
<th>Years of Involvement with FOCUS Pittsburgh</th>
<th>Paraprofessional/ community Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Fuller (1)</td>
<td>Female</td>
<td>50s</td>
<td>African American</td>
<td>-</td>
<td>Women’s issues/trauma</td>
</tr>
<tr>
<td>Ms. Carter (1)</td>
<td>Female</td>
<td>60s</td>
<td>African American</td>
<td>-</td>
<td>Community Social Activist (Education)</td>
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<tr>
<td>Mr. Cole (1)</td>
<td>Male</td>
<td>70s</td>
<td>African American</td>
<td>2</td>
<td>Retired Veteran</td>
</tr>
<tr>
<td>Mr. Marks (1)</td>
<td>Male</td>
<td>40s</td>
<td>Caucasian</td>
<td>2</td>
<td>Priest</td>
</tr>
<tr>
<td>Ms. Moore (1)</td>
<td>Female</td>
<td>40s</td>
<td>African American</td>
<td>4</td>
<td>Resident</td>
</tr>
<tr>
<td>Mr. Jones (1)</td>
<td>Male</td>
<td>50s</td>
<td>African American</td>
<td>3</td>
<td>School Coordinator</td>
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<tr>
<td>Mr. Abernathy (1)</td>
<td>Male</td>
<td>30s</td>
<td>African American</td>
<td>4.5</td>
<td>Director of FOCUS</td>
</tr>
<tr>
<td>Mr. Banks (2)</td>
<td>Male</td>
<td>20s</td>
<td>African American</td>
<td>3</td>
<td>Assistant Director of Programs at FOCUS</td>
</tr>
<tr>
<td>Ms. Rogers (2)</td>
<td>Female</td>
<td>30s</td>
<td>African American</td>
<td>1</td>
<td>Volunteer Staff at FOCUS</td>
</tr>
<tr>
<td>Name</td>
<td>Gender</td>
<td>Age</td>
<td>Ethnicity</td>
<td>Occupation</td>
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</tr>
<tr>
<td>-----------------</td>
<td>--------</td>
<td>------</td>
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<tr>
<td>Ms. Tally (2)</td>
<td>Female</td>
<td>40s</td>
<td>African American</td>
<td>Volunteer Staff at FOCUS</td>
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<td>Ms. Heath (2)</td>
<td>Female</td>
<td>40s</td>
<td>African American</td>
<td>Child Care Worker</td>
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<tr>
<td>Mr. John (2)</td>
<td>Male</td>
<td>20s</td>
<td>African American</td>
<td>Resident</td>
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</tr>
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<td>Mr. Mack (2)</td>
<td>Male</td>
<td>30s</td>
<td>African American</td>
<td>Janitorial work</td>
<td></td>
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<td>Ms. Mary (3)</td>
<td>Female</td>
<td>50s</td>
<td>African American</td>
<td>Non-Profit ED</td>
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<td>Ms. Holland (3)</td>
<td>Female</td>
<td>50s</td>
<td>African American</td>
<td>Social Activist (education)</td>
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<tr>
<td>Ms. Green (3)</td>
<td>Female</td>
<td>40s</td>
<td>African American</td>
<td>Community Organizer/ development</td>
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</tr>
<tr>
<td>Ms. Bell (3)</td>
<td>Female</td>
<td>60s</td>
<td>African American</td>
<td>Volunteer at FOCUS</td>
<td></td>
</tr>
<tr>
<td>Ms. Winter (3)</td>
<td>Female</td>
<td>50s</td>
<td>African American</td>
<td>Volunteer at FOCUS</td>
<td></td>
</tr>
<tr>
<td>Mr. Smith (3)</td>
<td>Male</td>
<td>30s</td>
<td>Caucasian</td>
<td>Psychiatrist (FPFHC)</td>
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</tr>
</tbody>
</table>

**Consultative Workshop**

A consultative workshop was held on the lawn of Focus Pittsburgh in a tent on April 26, 2014. The consultative workshop brought together experts in the field related to community trauma, key stakeholders from the Hill District community for the purpose of problematizing community trauma and potential strategies to address community trauma. The goal of the consultative workshop is to generate rich naturalistic data by identifying pertinent information linked with phenomena associated with community trauma, such as underlying issues related to potential barriers to mental health treatment (Levers, 2003).

A consultative workshop is essentially an extension of a focus group and has been used as a method by The World Health Organization (Ranson, Chopra, Atkins, Dal Poz, & Bennet, 2010). During the daylong event, 19 key stakeholders, four experts, and three facilitators attended the various informational sessions and focus groups. The format for
the day included four sessions and three break-out focus groups after the first three sessions, along with a concluding session, in which all the participants remained together. For each of the three sessions, a 10–15 minute PowerPoint presentation on a specific topic was presented to the all the participants. After each short presentation, participants attended their designated focus group. The repeated and recursive nature of the consultative workshop methods makes data generation and interpretation a highly iterative process (Levers, 2003). Focus group 1 included 7 individuals. Focus groups 2 and 3 had 6 participants, respectively. The three focus groups were held simultaneously and lasted about 45 minutes each.

**Analysis of Focus Groups**

Focus groups help generate “in-depth understandings of perceptions, opinions, and the ways in which people make meaning of a variety of aspects of life” (Levers, 2006, p. 381). My findings theorize multiple factors that are contributing to the idea of community trauma as experienced by key stakeholders in the Hill District community. The term community trauma as referenced in the literature is usually associated with a particular traumatic event(s), such as a hurricane, an industrial accident, war and genocide, mass shooting, or terrorism. My research suggests multidimensional origins that do not have one particular event as the cause, but rather multiple contributing factors, which also have the potential to be barriers to seeking treatment.

There were three simultaneous focus groups held at the same time and each group had its own unique group dynamic. Focus group 1 included eight members and one female facilitator (African American). The demographics included four males (three African Americans and one eastern European) and three females (all African American) and aged
in range from 30–70 years of age. Pseudonyms names for focus group 1 were Ms. Fuller, Ms. Carter, Mr. Cole, Mr. Marks, Ms. Moore, Mr. Jones, Mr. Abernathy (real name), and Ms. Hart (facilitator). Focus group 2 included six members and one female facilitator (Caucasian). The demographics included three females (all African American), three males (All African American), and ranged in age from 20–50 years of age. Pseudonyms names for focus group 2 were Mr. Banks, Ms. Rogers, Ms. Tally, Ms. Heath, Mr. John, Mr. Mack, and Ms. Conner (facilitator). Focus group 3 included six members and one female facilitator (Caucasian). The demographics of the group included five females (all African American) and one male (Caucasian). Pseudonyms names for focus group 3 are Ms. Mary, Ms. Holland, Ms. Green, Ms. Winter, Ms. Bell, Mr. Smith, and Ms. Edwards (facilitator).

The following paragraphs will give a brief description of the presentations content for each of three sessions, followed by a list of guiding questions, and a table highlighting the results from each focus group and each session. The reported results were generated from content analysis of the data from video of each session pertaining to guiding questions, and to add context and cross validate the newsprint notes each facilitator gathered during each focus group session.

**Session 1**

The topic for the first session was an introduction to Bronfenbrenner’s Bioecological Model of Human Development (1979, 2006) as a framework for analyzing community trauma and identifying potential protective and risk factors associated with the help-seeking process. The Bioecological model posits four defining properties: process, person, context, and time. Human development, especially in early life phases, occurs
through processes that gradually increase in complexity and are reciprocal interactions between the individual and persons, objects, and symbols in the individual’s immediate external environment. An individual is “nested” in proximal systems or environments closet in proximity to the individual and distal systems, which are systems or environments furthest away from the individual. Both proximal and distal environments influence human development over time. There are five systems or ecologies in the Bioecological Model, which consist of the *microsystem, mesosystem, exosystem, macrosystem*, and *chronosystem*. Participants learned the importance of “proximal processes,” which are consistent, prolonged, and reciprocal interactions between the individual and his or her immediate environment. These proximal processes are the essential building blocks of development, contributing to an individual’s motivation, skill, knowledge, and ability to perform daily tasks and build self-efficacy and resilience.

The Guiding questions asked during the first focus group session included:

- What is your response to what the speaker discussed?
- How does the information apply to the Hill?
- What are the protective factors involved in the help-seeking processes on the Microsystem, Exosystem, Macrosystem, and Chronosystem?
- What are the risk factors involved in the help-seeking processes on the Microsystem, Exosystem, Macrosystem, and Chronosystem?
- How do you think this needs to be addressed?
### Consultative Workshop Session #1 (Table 2)

<table>
<thead>
<tr>
<th>Focus group number #</th>
<th>Response to Presentation</th>
<th>Protective Factors</th>
<th>Risk Factors</th>
<th>How to Address Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus group 1</strong></td>
<td>Need to know the community and importance of collaboration with multiple entities in the Hill</td>
<td>Education--(e.g., OPH Sat. School, learning Black history)</td>
<td>Lack of trust</td>
<td>Mobile intervention--“bio-ecological care plan”</td>
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<tr>
<td></td>
<td></td>
<td>Data base of community-based services</td>
<td>Language</td>
<td>Take programming to the streets</td>
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<td></td>
<td>Follow-up</td>
<td>Crack epidemic</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Historical resilience of Black folk”</td>
<td>Lost ability to think for self</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Integration</td>
<td>Follow-up and Follow-through</td>
</tr>
<tr>
<td><strong>Focus group 2</strong></td>
<td>Looking to science/research for help</td>
<td>It starts with the family</td>
<td>Perceptions of the Hill (“Hill is like jail”/“the news is depressing”)</td>
<td>We need to unite</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Laws that impact treatment</td>
<td>Laws that impact treatment</td>
<td>“Trying to figure out a way to cope with life as colored people and gaining perspective”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>God/Higher power</td>
<td>“White people moving in” (re-gentrification)</td>
<td>Learning/ building skills to cope</td>
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<tr>
<td></td>
<td></td>
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<td></td>
<td>Accepting change</td>
</tr>
<tr>
<td><strong>Focus group 3</strong></td>
<td>“We know these types of models, but nothing has changed in our neighborhood. I am anxious to see what is the”</td>
<td>FOCUS Pittsburgh</td>
<td>Stigma (families)</td>
<td>Need paraprofessional to help navigate systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>God/ spirituality</td>
<td>“Black people treated differently than White people in healthcare”</td>
<td>“Build trust after a life time of betrayal”</td>
</tr>
</tbody>
</table>
Session 2

The topic for the second session was exploring community trauma. I was the presenter for this session. Participants were presented with definitions of trauma and community trauma and viewing trauma as a systemic issue. Participants were informed about the potential effects from traumatic experiences, and more specifically the effects of chronic community violence from the literature. Cultural and social justice issues related to trauma were also presented. Guiding questions asked during the second breakout session included:

- What is your response to what the speaker discussed?
- How does the information apply to the Hill?
- How would you define “community trauma?”
What may influence or perpetuate community trauma using the Bioecological map?

Using the Bioecological map what are the assets of the community in relation to addressing community trauma?

Using the Bioecological map what are the needs of this community in relation to addressing community trauma?

**Consultative Workshop Session #2 (Table 3)**

<table>
<thead>
<tr>
<th>Focus group number #</th>
<th>Define Community Trauma (CT)</th>
<th>Community assets</th>
<th>What influences/perpetuates CT</th>
<th>How to Address Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus group 1</strong></td>
<td>Chronic community Violence</td>
<td>Leadership academies (training kids to be leaders and letting them lead)</td>
<td>Desensitization of violence</td>
<td>Listen to the youth</td>
</tr>
<tr>
<td></td>
<td>Psychological damage</td>
<td>FOCUS</td>
<td>Indirect impact “hearing about it” (violence)</td>
<td>Spiritual aspect of healing</td>
</tr>
<tr>
<td></td>
<td>Layers of Trauma (e.g., housing, hunger, lack of health care, poverty, under-employed)</td>
<td>“Strength of Black folks”</td>
<td>“Feeling hopeless”</td>
<td>Build self-awareness</td>
</tr>
<tr>
<td></td>
<td>Racism</td>
<td>Resilience</td>
<td>“Feeling helpless”</td>
<td>Need funding</td>
</tr>
<tr>
<td></td>
<td>Difference between Black and White diagnosis and neighborhoods</td>
<td>Influence of women in the community</td>
<td>“Feeling powerless”</td>
<td>Collaboration in the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“Not seeing people of color working”</td>
<td>Have a common understanding of community trauma</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus group 2</th>
<th>Trauma impacts every aspect of your life</th>
<th>Teachers, nurses, doctors</th>
<th>Negative coping mechanism</th>
<th>Community needs to create opportunities for healing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gangs</td>
<td>“How do you know it is a”</td>
<td></td>
<td>Prevention</td>
</tr>
</tbody>
</table>
Drug trafficking
“Loud/crime is normal in the Hill”

Defining trauma:
“anything that negatively affects a person, such as drugs, homelessness, and crime.”

trauma, if you are used to things” (trauma)

“When does it become the responsibility of the individual to seek treatment?”

“Start something, but do not finish” (Hill initiatives)

Focus group 3
Community violence
Son murdered/
Mother murdered/
Brother murdered/cousin murdered

“We are born into trauma, we live in trauma, we die in trauma. There is not an answer.

Community professionals
Caregivers
-Negative coping mechanism (e.g., detachment, addiction)
Covert/overt racism
How to handle grief
Distrust and mistrust of people and institutions

-Process of rebuilding trust in the community
Need safe place to tell story
Caregivers and professional need support

“Some people think Black women are so strong.”

-Lack of healthy friends and peer networks
Session 3

The third session provided information about the ACE study (Felitti, et al., 1998). The ACE study (1995-1997) is the largest study to date, with more than 17,000 participants, which has linked health risk behavior and disease in adulthood to exposure to emotional, physical, or sexual abuse, and household dysfunction during childhood. The participants were informed about the study’s findings. Some of the information shared included significant relationship between adverse childhood experiences and alcoholism, drug abuse, sexual promiscuity, sexually transmitted diseases, intimate partner violence, obesity, physical inactivity, depression, suicide attempts, and smoking. The more adverse childhood experiences reported, the more likely a person will develop heart disease, cancer, diabetes, liver disease, stroke, and skeletal fractures. The ACE study illustrates that adverse childhood experiences are more common than acknowledged and the impact these adverse experiences has on physical and behavioral health later on in life and the need for preventative interventions. Guiding questions asked during the third breakout session included:

- What is your response to what the speaker discussed?
- How does the information apply to the Hill?
- Using the Bioecological map what are the main problems with this in the Hill?
- What are the attitudes towards mental health? Treatment?
- Using the Bioecological map, what may influence these attitudes?
- Using the Bioecological map, what are potential barriers to treatment?
<table>
<thead>
<tr>
<th>Focus group number #</th>
<th>How does ACE study apply</th>
<th>Attitudes towards mental health</th>
<th>What influences attitudes toward mental health</th>
<th>Barriers to treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus group 1</strong></td>
<td>“Aha moment for the community”</td>
<td>Distrust of systems/institutions</td>
<td>Stigma (family, peers, community)</td>
<td>Feeling there is no safe place to tell story</td>
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<td></td>
<td>“That would explain some things that seemed unexplainable”</td>
<td>“The system does not care where or with whom I share my story”</td>
<td>“if you tell…your mom would say, I will kill you…”</td>
<td>Stigma</td>
</tr>
<tr>
<td></td>
<td>Cycle of generational violence in the home</td>
<td>“Hard to navigate in a fragile mental state”</td>
<td>Trans-generational trauma</td>
<td>Mistrust of everyone, even in the community</td>
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<td></td>
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<td>“I think it is cultural”</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Need system to understand microsystem and collaborate (cultural barrier)</td>
</tr>
<tr>
<td><strong>Focus group 2</strong></td>
<td>“There are some parents who look at their child and dislike their child because of who their father was.”</td>
<td>Distrust of the system</td>
<td>Abandonment</td>
<td>“what goes on in the house stays in the house”</td>
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<tr>
<td></td>
<td>“a lot of people put titles on their children. “he is so bad or he is a demon in disguise….children take on that identity.”</td>
<td>Negative peer/friend support system</td>
<td>Family judgment (stigma)</td>
<td>Stigma (individual, family, community)</td>
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<tr>
<td></td>
<td>Broken family system</td>
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<td></td>
<td>Being misdiagnosed</td>
</tr>
</tbody>
</table>
Focus group 3

“I could relate…I didn’t know it could start in childhood”

“I should have know, but I do now…that it effects how you think and the decision you make in life...”

“My exploratory research findings suggest five main contributing risk factors influencing community trauma in the Hill District and the help-seeking process. The five factors are stigma, chronic community violence, social determinants (e.g., poverty, inequities, unemployment), racism, and transgenerational or historical trauma (Sotero, 2006; Heart & DeBruyn, 1998). A few protective factors were identified from the focus groups, which included community non-profit organizations, historical resilience of African Americans, and spirituality/religious affiliation. Note, that my research findings show that churches and pastors in the community have been historically a protective factor and a place of sanctuary, but many of the key stakeholders reported a growing lack of trust of church leaders. The following paragraphs will link the narratives collected from the focus groups to the themes/factors mentioned above using van Manen’s Lifeworld Existentials.

Lived Space (Spatiality)

Lived space is not only the physical space in which an individual resides; it is how an individual experiences his or her being in the day-to-day activities of life. Driving up to the Hill from downtown Pittsburgh on the main connecting avenue, one is first
greeted by a large Catholic Church with a towering statue of St. Benedict the Moor with out stretched hands on top on your left and Freedom Corner on the right. Freedom Corner was created to mark and memorize the Hill community’s stance against the City’s urban renewal of the 1950s and 1960s that demolished much of their community. This corner also symbolizes the memory and spirit of the Civil Rights movement and the fight for equality and social justice. This corner was and is still the starting point of most of the City marches for social change. As one continues up into the Hill, one is flanked by newer townhouses that were built about twenty years prior initially of mixed-income housing. More signs of revitalization are apparent continuing up the Avenue, a new shopping center, grocery store, a renovated building, new senior citizen apartments, a new library, and a new YMCA. As one continues on the avenue, however, the new buildings and well-kept houses become increasingly rare.

FOCUS Pittsburgh is on this main street, housed in a rented row house between a school and a double vacant lot. The building’s paint is faded and reflects its 100-year age. One of the front windows is boarded up after being recently broken. Rather than thriving, the building, as Ms. Fuller has stated, “reflects the community” that it is trying to survive. Although the esthetics inside and outside of the building are probably a metaphor for how many in the community feel, the space inside has transcended the esthetics, providing a sanctuary for community members. The downstairs of FOCUS is a drop-in space where community members can get basic goods like clothing and housewares. There are paintings, icons, and pictures on the wall representing African-American history and the Christian Orthodox religion. To the right of the front door clothing racks are nestled against the wall with a couch in front of them. The opposite wall has shelving for the
housewares and two folding tables in front of the shelves. The two tables are often used as a staging and packing area for the backpack feeding program or weekly dinners. There is a desk in the middle of the room by the wall where staff conducts business. Towards the back of the room are a refrigerator, coffee maker, and small prayer altar where daily prayers are said. The space is not very large and usually filled with people of varying ages. Multiple conversations are usually happening at the same time. This is when the space transcends its esthetics; it becomes a safe place for people to tell their stories and form authentic relationships. It is where an offer of a cup coffee becomes a vehicle for human connection. Ms. Winter reported, “I have been on my own since I was a child…I have nobody…that is why I come to FOCUS…I am here for the love” (focus group 3 session 3).

The lived reality of a low SES urban community is more apparent when one turns off of the main avenue. Dilapidated and vacant houses appear more frequently. An example of lived space in this community in relation to an aspect of community trauma was Mr. Banks interpretation of his environment. He states, “the Hill is like jail…live the Hill don’t let the Hill live you” (Focus group 2 session 1). For Mr. Banks who has been incarcerated before, the Hill environment represents jail. The concept of jail can mean an individual has been confined to a designated environment against his or her will. Jail reflects being punished for a crime. In many respects, jail strips away individual rights afforded to most citizens and dictate the individual’s daily routine. When I imagine a jail, I think being trapped or of not being free to make decisions about my day-to-day activities or imagine myself actualizing my full potential. This feeling of being confined, or trapped, or not having agency can become part of my identity. This identity has been
shaped and formed by my experiences of my lived space as a jail. This can lead to a life resigned to living within the confines, culture, unpredictability, violence, subjugation, and radical isolation prescribed by the jail environment. I attended a meeting with Mr. Abernathy with a potential collaborating partner on this project and the topic of the conversation was on youth in the Hill. I am paraphrasing Mr. Abernathy’s comments, he reported that a large number of young people have never left the Hill; they don’t really interact with White people or environments different than their own cultural context, and they are afraid to go downtown. Their worldview is shaped by their immediate lived experience of the Hill. The second part of Mr. Banks quote, “live the Hill, don’t let the Hill live you,” reflects the potential reframing of Mr. Banks lived space and an illustration of personal agency over his or her own environment.

van Manen (1990) suggests that lived space is largely pre-reflective, in that most individuals do not frequently reflect on daily interactions with their environment. An example of this pre-reflective idea of lived spaced frequently reported in the focus groups centered on the normalizing and desensitizing of violence of community members. The following are two representative examples from the focus groups that illustrate normalizing and desensitization of the community. Mr. Cole reported about his perception about trauma in the Hill is so pervasive that “it is no longer an individual illness, but a community illness…where the community is so desensitized on that which is happening” (focus group 1 session 2). Mr. Cole’s meaning generated from his lived space is that the community has been so desensitized to violence that it is no longer a healthy environment and no longer an individual mental health issue but one that has to
be addressed at the community level. Or as Mr. Banks states, “crime is normal to me…seeing a dead body is nothing new to me” (focus group 2 session 2).

Another theme that arose from the focus groups about lived space was the difference between predominantly White communities and predominantly African American communities. “The difference between White communities and Black communities is that White communities don’t know it is happening. Everyone in our community knows the trauma that is happening” (Mr. Abernathy, Focus group 1, session 2). The meaning that can be drawn from this statement is that interpersonal traumas happen in both predominantly Caucasian and African American communities, but in urban African American communities, “hearing about” is more common either through community members or the media. The perception of this “hearing about” victimization and violence is that it can reinforce the idea that the individual is not safe or secure and suggests the community lacks the resources to keep the individual safe (Horowitz, Weine, & Jekel, 1995). Or, “My people are straight out…we are the people that are doing this [selling drugs]. We hangout more than White areas, like Mt. Lebanon…White people hide what they do, we do not” (Ms. Heath, focus group 2, session1). These two examples from the focus group illustrate not only how space can influence meaning making and identity formation, but lived separation and difference between “Black” and “White” communities.

**Lived body (Corporality)**

Lived body is an individual’s understanding of his or her physical presence in the world. An overwhelmingly majority of participants in the focus group spoke about being Black and being discriminated against based on the color of their skin. Many participants
reported not receiving the same treatment as their White counterparts or being
misdiagnosed in the healthcare system. Ms. Holland, in her reply to a question about
mental health disparities and barriers to treatment, commented about, “going to the
hospital and being treated as dirt.” (focus group 3, session 2). In addition to the pervasive
experiences of institutional racism that many reported, the effects of community trauma
has influenced low self-esteem or “vacant esteem” (DeGruy, 2005), as well as not feeling
connected to others. A representative example of the process of trying to reconnect with
the world after trauma experiences would be Ms. Mary. “I am tired of wearing Black! “I
am in here, but, I want to come out, but there is so many layers of life, that are wrapped
around that it takes time to get to…” (Ms. Mary, focus group 3, session 2). Or as Ms.
Carter states, “we are the walking wounded” (focus group 1, session 1). Another theme
that arose in focus group 3 was how over extended and tired volunteer, paraprofessional,
and local agency staff members feel towards their work to make positive changes in their
community. “At work I am a thing, not a person! No one calls me to ask how I am doing.
Some days it is a very lonely place. Some people think Black women are so strong” (Ms.
Green, focus group 3, session 2). This statement reflects not only the objectification
experienced by Ms. Green but also deeper cultural issues related to the identity and role
of women in the African-American community.

In addition, the number of stories reported in the focus group relating to violence
was numerous. Ms. Mary’s son was murdered; Ms. Holland’s brother was believed to be
murdered; Ms. Moore’s sons have been shot numerous times; and Mr. Banks’ has witness
numerous friends shot and killed. Mr. Abernathy reports a friend who has lost 40 friends!
Not only are these experiences of violence pervasive in this community, the violence
exists on multiple levels from experiences of interpersonal violence to hearing daily stories of violence from community members or in the media.

**Lived Time (Temporality)**

Lived time is an individual’s biography; it is the past influencing the present and the future, as well as the present or future influencing the past. Lived time for many in the focus groups was fundamental in their identity formation, meaning making, and worldview. The experience of adverse childhood experiences (ACE) and the emotional, psychological, and physiological effects those experiences can have on an individual was an “aha” moment for many in the focus groups. The participants after hearing the presentation on the ACE study (Felitti, et al., 1998) identified with the results, as it provided a context for the distress many of the key stakeholders had experienced or witnessed in the community. For example, Ms. Fuller reported, “that would explain some things that seemed unexplainable” (focus group 1, session 3) or Ms. Bell reporting, “I didn’t know this could affect what happened in childhood with adults…I should have known, but I do now… that it affects how you think and the decision you make in life” (Focus group 3, session 3). Ms. Winter who is in the same focus group as Ms. Bell follow-ups on her comment, stating:

… It takes an effect on your children as well…especially after my mother’s death… the family was ok, my family was on the right track, but after my mother’s death. It seems like I forgot about my family… they are still good kids, but I think they could be better than they are… I think I got them off track… I don’t know… I think I messed up somewhere along the line, because I kept
running away from my own problems…my family is not close anymore…I don’t have a family anymore…(focus group 3, session 3).

When Ms. Winter finishes her statement Ms. Bell reports she feels the same way. This theme of loss and grief was very prevalent in all the focus groups, in that almost all the participants had lost family members or close personal friends due to violence. In addition, participants consistently reported there was no safe place to tell their story of grief and loss and begin to heal.

Another primary theme related to lived time reported in the focus groups was the idea of transgenerational and historical trauma. Transgenerational and historical trauma theorize the psychological and emotional scars from the trauma of slavery are passed down to the next generation through physiological, environmental and social pathways resulting in an intergenerational cycle of trauma responses (Sotero, 2006). As reported above many of the key stakeholders reported multiple adverse childhood experiences, which could be a result from the intergenerational cycle of trauma responses passed down through the generations. Or, as DeGruy (2005) describes the effects of slavery as a “legacy of trauma.” This legacy of trauma reflects behaviors and beliefs that were necessary to survive during slavery but are ineffective and often undermine an individual’s ability to reach his or her full potential. Often this legacy is passed down through parenting styles. Many in the focus groups reported violence in the home. In a discussion in focus group 2 about parenting and structure, it was reported that it was common for neighbors to “beat you” if you misbehaved. The legacy of trauma is not only passed down through families but also can be passed down through the community. For many in this community, the lived reality of just “trying to survive” is a legacy of trauma
and can directly influence an individual’s and a community’s future potential and identity formation.

**Lived Other (Relationality)**

Lived other is an individual’s interactions with others or relationships that share space in his or her life. Lived other brings to the forefront interpersonal themes and projections made about others when interacting with them. One of the primary effects of trauma is feeling disconnected from others and trusting (Herman, 1992/1997). A common theme shared in all the focus groups was a distrust of institutions and mistrust of peers and even family members. Ms. Rogers told a story in her focus group about getting her finger cut-off by a friend, who then left her to die. She started to drink heavily to cope. She reports that some time later she was at a party, needed a ride home so she called a Jitney (i.e., local cab service) for a ride home. On the drive home the Jitney driver took an alternative way back to her house that Ms. Rogers was unfamiliar with and she was triggered back to her trauma experience and feared for her life. She states, “I didn’t trust anyone…He [friend] put a fear in me…it took me a long time to trust again” (Focus group 2, session 2). Ms. Green’s experience of fear and struggling with trusting others as a result of a traumatic experience would be consistent with other key stakeholder reports, such as Ms. Rogers, Ms. Tally, Ms. Bell, Ms. Winter, and Ms. Holland. Or, as Mr. John reports, “I shut people out, that is how I cope” (focus group 2 session 2).

The mistrust reported from the participants’ not only stems from interpersonal traumas, but is also influenced by transgenerational trauma or historical trauma passed down through the generations. In addition, the mistrust of others is related to being stigmatized or fear of having your story shared around the neighborhood, and being...
judged. “Someone has to notice the other is hurting or beginning to heal. How to stop the judgment?” (Ms. Mary, focus group 3, session 2). Stigma, the feeling of judged by others or negative labeling, was also reported to start at a very young age. Ms. Tally reported, “I heard someone recently who said, I thought my son was Satan when he came out… Ms. Heath, I have heard that too” (focus group 2, session 3). Ms. Tally continues, “there are some parents who look at their child and dislike their child because of who their father was” (focus group 2, session 3). Or, “a lot of people put titles on their children. “He is so bad or he is the demon in disguise… children take on that identity. (Ms. Heath, focus group 2, session 3). Participants in the focus group all reported about negative labeling that occurred in their community, especially with children, whether it came from inside the family system or community, or from outside forces, such as in the media. For example, “if you don’t know you come from excellence, you don’t think you can achieve excellence.” (Ms. Fuller, focus group 1, session 1). The data suggests healthy interpersonal relations are difficult to form, maintain, and often are strained because of the negative labeling or judgment, cycle of trauma responses, and the residuals of historical trauma.

**Major Findings/Themes**

The following section identifies the major themes from my research. The specific themes covered are stigma, chronic community violence, social determinants, racism, and transgenerational and historical trauma. In addition, I will describe the protective factors articulated by key stakeholders during the focus groups. Each specific theme is described below.
Stigma

Stigma has been reported as one of the primary barriers to treatment by SAMHSA (2013). The World Health Organization reported in their 2001 annual report about that the brutal effects stigma can have on millions of people who suffer from mental illness. As reported in chapter one and two, the literature on attitudes and beliefs of ethnic/racial minority groups in relation to seeking mental health treatment are paradoxical and inconsistent. Some studies show that stigmatizing attitudes are a barrier to treatment (Anglin et al., 2006; Fogel and Ford, 2005; Rao et al., 2007), while other studies claim the opposite (Diala et al., 2001; Givens et al., 2007). A recent study by Jimenez et al., (2012) found no significant difference in attitudes or beliefs between African Americans and non-Latino Whites use of mental health services. My research findings are more consistent with the later. Stigma reported in all the focus groups were related to family and community disproval of seeking help, which could be related to a historical distrust of the public health system as a result of unethical and harming medical experiments performed on African Americans (e.g., Tuskegee syphilis experiment). Mr. Smith who is a volunteer psychiatrist at FOCUS asked in focus group 3, “Where does the lack of trust from this community come from?” Ms. Holland responds, “From bad experiences…going to the hospital and being treated as dirt or harassed by cops or being at a store and shop people following you.” Or “We don’t trust the mental health system” (Ms. Green, focus group 3, session 2). To help conceptualize the multiple layers of stigma reported in my research, Corrigan and Ben-zeev’s (2011) understanding of stigma is useful.
Corrigan and Ben-Zeev (2011) separate stigma into four levels. The levels include, public stigma, self-stigma, label avoidance, and structural stigma. Public stigma relates to large social groups who support stereotypes about individuals with mental health issues and act against them. Examples of public stigma reported were churches, families, as well as friends and peer groups. Self-stigma is the effect from public stigma where individuals internalize the negative stereotypes that can result in lower self-esteem and self-efficacy. Label avoidance arises when an individual chooses not to seek treatment, because he or she does not want to be labeled due to the possible suffering from the prejudices as a result of the label. Structural stigma relates to intentional discrimination by private and governmental institutions as well as policies that can restrict opportunity for individuals with mental health issues.

Corrigan and Ben-Zeev’s articulation of the levels of stigma give insight into the paradoxical results in the literature. In that, stigma can be filtered through the context of an individual’s living environment. Similar to Bronfenbrenner’s Bio-ecological Model of Human Development (1979, 2006), Corrigan and Ben-Zeev’s four levels of stigma relate to the micro and macro-social systems. The micro level is the individual’s social cognitive processes of public stigma, self-stigma, and label avoidance. The public stigma reported by many in the focus groups was influenced on the micro and macro-social levels. Much of the public stigma was associated within the family system. Consistent expressions shared were “what happens here stays here…I am disrespecting my family if I get help” (Ms. Green), or as Ms. Rogers stated, “even if I wanted to get help…Parents did not want information to go outside the house.” Another example reflects the influence of peer and friend groups. Mr. Mack shared a story when he was an adolescent, he had
sought out professional help and was on medication, his friends told him, “just drink this beer, you don’t need that pill.” Mr. Mack’s experience not only relates to the micro-social level, but the influence of the wider macro-social system influencing what is considered culturally “normal” or acceptable in this community. In other words, the macro-social level relates to the social phenomena of stigma. For many in the focus groups, the cultural norm instilled in them at a very young age was, “do not go outside the family,” and “do not trust others,” especially the larger structural systems (e.g., CYFS, schools). The possible reason for the pervasive experiences of stigma by many in this community could be related to the effects of historical trauma (Sotero, 2006), or DeGruy’s (2005) idea of Posttraumatic Slave Syndrome. The effects of stigma experienced in this community has created a culture of silence where people are afraid to tell their story of suffering and pain, which can often result in feelings of isolation, low self-esteem or vacant esteem, negative coping-mechanism, and depression.

**Chronic Community Violence**

A predominant theme from all the focus groups was violence in the community. My research findings show all most all the key stakeholders reported experiences of violence personally or have been impacted by violence in their life. For many their childhood traumas were not addressed until they were adults (e.g., Ms. Tally and Ms. Rogers). Some of the different forms of violence experienced were sexual abuse and assault, emotional and physical violence in the home, and chronic community violence. Ms. Moore shared her story of her two sons being shot and the impact it had had on her. She states:
Two of my sons getting shot many times, two to three times…and usually when I hear gunshots I jump. Constantly in my sleep I worry…it is a traumatized thing that I never know when…It's a shame and sad, but I am starting to get used to…like, when is the day going to come and that is sad, you know, because the generation, the stuff you see every day on the news. When I am in my house I don’t know if a bullet is going to come through my window…they [sons] have been shot on porches, in alleys, sandwich shops (focus group 1 session 1).

Ms. Fuller responds to Ms. Moore’s story by stating, “imagine Ms. Moore’s story multiplied 10, 20, 30 times, people feel hopeless and powerless” (focus group 1 session 1). Ms. Mary spoke about her son being murdered. Ms. Winter’s mother was murdered. Ms. Holland’s brother and cousin were killed. Ms. Rogers had her finger cut-off by a friend and was left for dead. Mr. Banks and Mr. Mack reported that they used to be in gangs. Mr. banks who was a former gang leader stated, “Crime is normal for me…I was in the gang lifestyle. Although, I am not in the gang life anymore, that lifestyle is still following me…Seeing or hearing friends getting killed, seeing a dead body or dealing with death is normal to me” (Focus group 2 session 2). As a result of the chronic community violence experienced inside and outside the home, the violence has become normalized as Mr. Banks reports or as Mr. Cole suggests it is a “desensitizing of the population” (focus group 1 session 2). Chronic community violence as it was reported in the focus group could be considered an epidemic in this community.

**Social Determinants**

Like many other urban and racial/ethnic neighborhoods around the country, the Hill District suffers from substandard housing and education, higher unemployment rates,
poverty, higher rates of incarceration, and lack of access to resources. Not only have these social determinants been linked to health disparities in racial/ethnic minority groups (Primm et al., 2010), my data indicate these social determinants contribute or exasperate the idea of community trauma in this community. The following statement illustrates the multiple layers or forms community trauma experienced in this community. Ms. Carter states,

I think there are other types of trauma…layers of trauma. It is traumatic for child to be hungry… It is traumatic for a mother not able to provide for her child… It is traumatic not to have a house or one that is dilapidated… It is traumatic not to have health care or go to a provider who does not understand you or respect you… It is traumatic living in poverty… It is traumatic when you hear gunshots… It is traumatic when there is violence in the home… It is traumatic when children do not get the education they deserve… there are lot of different stressors with trauma… being under-employed… (focus group 1 session 2).

The last statement of Ms. Carter’s litany of layers of community trauma produced an immediate vocal reaction and head nodding in agreement from all the group members. As a follow-up to Ms. Carter’s statement, Ms. Fuller reported that she had lived away from the Hill for 15 years and when she returned in the 1980s she could not believe she did not see any “men of color” working in downtown Pittsburgh. She was living and working in Washington DC until her return to the Hill and she was not used to seeing this many unemployed Black men. "I was depressed about it” “there was a life style, I became aware of [in DC]… we should be a part of the American dream” (focus group 1, session 2) Along with African Americans being under-employed many of the participants spoke
of the disparities in the criminal justice system. Ms. Tally commented, “What a White person may get and that of a Black person are much different” (focus group 2 session 2). Many in the focus groups referenced the idea of the “street culture,” and the allure of drug trafficking. “My people are straight out. We are the people that are doing this [selling drugs]. We hangout more than White areas like Mt. Lebanon” (focus group 2 session 1). Social determinants identified from the focus groups include poverty, unemployment, substandard housing or home ownership, below-average schools, “street culture” (e.g., gangs, drug trafficking), and disparities in the criminal justice and healthcare systems.

Racism

African Americans report more incidences of racism than any other racial/ethnic minority group in the U.S. (Kessler, Mickelson, & Williams, 1999; Pieterse, Carter, Evans, & Walter, 2010). During the focus groups, participants reported racism on the individual, community, and institutional level. On the individual level participants shared stories of being followed by store personnel as they shopped, or getting on an elevator in the city with White women and watching them clasp their purses as soon as they got on the elevator. One profound story shared in focus group 3 relates to cultural racism and the effects racism can have on identity formation. Ms. Holland shared about when her daughter was in middle school and was walking over one of the many bridges in Pittsburgh to go to the store. As she was walking over the bridge, she saw painted in large letters, “Malcolm and King…two dead niggers.” Ms. Holland had to explain to her daughter what it meant, why someone would write that, and the realities of racism that she will encounter in her life based solely on the color of her skin. Ms. Holland
continues, “The small things, subtle racism it makes you hard...people locking car doors, people holding their purses tight. Americans allow this to happen. America was built on racism” (focus group 3 session 2). At the institutional level participants talked about being treated differently in the healthcare system and receiving different treatment protocols than their White counterparts. Ms. Carter, “this goes back to racism that is structural and systemic…in health care” (focus group 1 session 2). Another form of institutional racism raised in the focus groups was fear and a lack of trust in law enforcement. Ms. Heath reported about a “secret ballot” initiative by the local police, which for residents sounded like a good plan to anonymously inform police about crimes, drug trafficking, etc. But when the secret ballots came in the mail, all the ballots had numbers on them, and the residences deduced that the City would know what residence submitted the information. Residents were afraid the ballots were not confidential and the potential for retaliation if their information was leaked. This initiative added to the community’s distrust of law enforcement. The experience of racism, whether “perceived” or not, is very real and is a major stressor contributing to community trauma.

**Transgenerational and Historical Trauma**

Historical trauma theory provides a macro-level observation of how time and space in its investigation of the life experiences of a population exposed to trauma at a certain point in time relates to an unexposed population. Historical trauma theory posits that psychological and emotional scars from the trauma of slavery are passed down through succeeding generations through physiological, environmental and social pathways resulting in an intergenerational cycle of trauma responses (Sotero, 2006, p. 95). For many in the focus groups the residuals of historical trauma are a part of everyday
life and identity formation in this community. Ms. Holland stated, “We are born into trauma, we die in trauma, we live our lives in trauma, there is not an answer…” (Focus group 3 session 2). Ms. Carter was more overt about the influences of historical trauma on the community and about her skepticism of my research project. She states:

Let’s address the real idea of Historical trauma of racism and poverty! My focus is on the children… People are the walking wounded…we have to address the systemic issues. How do we heal? Whose lens are we looking through? Is this Euro centric? Duquesne has to be careful…this is structure. This has been going on for hundreds of years. We have to address the whole spectrum, not just children, or vets…[we] must deal with slavery and trauma! (Focus group 1 session 1)

Mr. Abernathy comments further on the possible structural affects from American chattel slavery that has been passed down through the generations, which may be influencing the community’s lack of agency to affect change. Mr. Abernathy is responding to the group discussion about the lack of funding available to the community to make change. He states:

We have institutionalized our response to change…we need funding, but the Civil Rights movement did not happen because of funding…it might be because so many of us have been institutionalized…in foster care, have been incarcerated, that we need an institution to make the changes for us. We have been too reliant on institutions far too often… people say, ‘what am I going to get out of it?’ not looking after one another (focus group 1 session 2).
This “not looking out for one another” in the community and “what am I going to get out of it,” has lead the community to fragment in many ways.

The fragmentation and disunity in the community may have paradoxically arisen from the “pseudo” integration that took place in the U.S. in the 1960-70s. Mr. Cole states, “the downfall of our culture was integration, our grandkids lost that unity…it is all about me” (Focus group 1 session 1). Mr. Cole was alluding to the “Wylie Ave Days” of the Hill, when the Hill was overtly segregated, but the community was self-sustaining and self-reliant. In addition, a common theme reported in all the focus groups was distrust of institutions, such as the healthcare system, judicial system, local government, law enforcement, churches, and a general mistrust of people. For example, referring to why African Americans do not use the healthcare system or other agencies, Ms. Mary stated, “what drove them to not want to come in? Kept getting the short end of the stick, then there was no stick… look at our four fathers…we are putting down a foundation…if you want to help us than do that…. ” (Focus group 3 session 1). Or, as Ms. Green stated, “[we] don’t trust the mental health system” (focus group 3 session 1). Also, the distrust in institutions was reported to stem from various groups or entities coming into the community and leaving, without much change. As I was going through the informed consent form with the participants in the opening session of the consultative workshop, Ms. Fuller challenged my intentions about the research and asked about my commitment to the community. I paraphrase her comments to me: our community has been researched to death, groups come in do a research project, promise this or that, and then leave when the research is done. Nothing ever comes from the research, she concluded. In addition to a distrust of institutions outside the community, there is also a distrust of local institutions
and community leaders, as well as a general mistrust of community members. Mr. John states:

If we do no unite soon it is going to get worse. Now the churches that you used
look up too…used to run to…you can’t run to a church, because you do not know
if the pastor is right. What I mean by right, you do not know what he doing
something that he doin’ that is crooked. People are afraid to go to church these
days…lack of trust of pastors…Pastors are not out in the community. They are
scared (focus group 2 session 1).

Historically churches in the African American community were a sanctuary, a safe place
go, and a vehicle for social change. Mr. John’s statements illustrate a common theme in
the focus groups: the local churches are seen less as protective entities and more as
potential risk factors. He also alludes to a general community fear of the environment felt
individually and as a collective, including a fear of church leaders.

Protective Factors

Protective factors expressed during the focus groups included historical resilience
of African Americans, existing community-based services, and reliance on God or higher
power (see table 2). Many in the focus groups identified FOCUS Pittsburgh as a
community-based organization that offered a “safe place” to receive assistance or to
connect with other community members. FOCUS was identified as an “authentic
sanctuary” as well as a community driven organization that “reflects the neighborhood”
and is truly serving the community. For example, Focus group 1 was meeting in one of
the exam rooms on the second floor where the free health center is housed. The exam
room is a converted bedroom, and doubles as a meeting room and conference room.
Other agencies identified as protective factors included Saturday schools where youth would learn about African American history and learning academies directed at training the youth to be leaders. Another protective factor identified was the “strength of Black folks,” and the historical resilience of African Americans. For many in the focus groups the Historical resilience of African Americans relates to the idea of enduring generations of slavery, Jim Crow laws, segregation, and “we are still standing” (Ms. Carter). The last major protective factor identified from the focus groups was a belief in God or a higher power. Even through it was reported there was a current mistrust and distrust of some pastors and local churches, a belief in God or a higher power was integral and identified in all three focus groups as a protective factor.

**Applied Research: Consultative Workshop and Follow-up Focus Groups**

My research method used Rapid Assessment process (RAP). RAP is the preferred method when studying public health issues for three central reasons (Needle et al., 2003). One, it is relatively inexpensive and collects locally relevant data related to emerging risk behaviors. Two, it shortens the time between research and implementing culturally sensitive interventions. Three, helps to address some of mistrust and resistant to research that is often found in ethnic and racial minority communities, as well as to help build rapport (Needle et al., 2003). The consultative workshop was the vehicle through which RAP was utilized.

The final session of the consultative workshop brought together all three focus groups and each group presented a summary of their group discussions related to each of the three session topics. The final session in many ways was a “plea” of some sorts, for the community to “come together” to address community trauma, and ultimately to begin
the healing process. For many, the problems are already known; it is addressing the issues that is problematic. It was reported that a lot of research has been done in the community; many programs have been started, but the feeling from the key stakeholders was that nothing substantial changes. The main charge from the consultative workshop was that the key stakeholders would be invited back for a reunion in about a mouth, where I would present my preliminary findings from the workshop and a community action plan would be presented. For the community the consultative workshop and the research generated from it would mean nothing unless a real plan and community interventions are employed. During the time between the consultative workshop and the follow-up focus group meeting on June 12, 2014, I did an initial analysis of all the focus groups from the videotapes, facilitator newsprint notes, relevant literature review, and my observations to generate major themes and outcomes from the consultative workshop. From these findings, I met with Mr. Abernathy and other FOCUS staff/volunteers who participated in the consultative workshop to generate an initial proposed community driven behavior health vision to combat community trauma. The initial name of the vision was called a “Bioecological Care Plan.”

On June 12, 2014 all the participants were invited back to FOCUS to engage in a collaborative conversation about my preliminary findings from the consultative workshop, and give feedback and input on a proposed vision for the community’s response to community trauma. 10 individuals from the consultative workshop, one new long-time community member, Mr. Lawson (pseudonym), Dr. Levers, and I participated in the follow-up focus group. The participants from the consultative workshop who attended the meeting were, Ms. Heath, Mr. Banks, Ms. Rogers, Ms. Mary, Ms. Bell, Mr.
Smith, Ms. Tally, Ms. Moore, Mr. Abernathy, and Ms. Edwards. It is worth noting that between the time of the consultative workshop in April and the follow-up gathering, the FOCUS Pittsburgh Free Health Center (FPFHC) opened and started seeing patients. The following information was generated from the videotape of the follow-up focus group, personal notes, as well as an informational handout each participant received about the proposed vision and my preliminary findings (appendix I).

The focus group met at FOCUS on the second floor in one of the exam rooms of the newly opened FPFHC. Mr. Abernathy began the session by stating, “We are action-orientated,” which was a strategic attempt to dispel a deep-seated community belief that “nothing comes from research” or “there is never any follow-through” in the community. After Mr. Abernathy’s brief introduction to the evening, I presented my initial findings to the group. The findings that I shared with the group were an abbreviated version of the five factors or themes contributing to the idea of community trauma that can also act as barriers to treatment. The five themes included stigma, social determinants, chronic community violence, racism, and historical or transgenerational trauma, which I have already articulated in this chapter. All of the participants were in agreement with my findings and the results represented the lived experience of the key stakeholders present at the consultative workshop.

Next, Mr. Abernathy presented what he coined as the “Bioecological care plan” to the group. Major points from the vision shared included the following. (a) The plan will use a community driven behavior health method employing holistic approach to well-being. (b) A medical safety net has already been provided through the FPFHC in the community, which addresses access issues. (c) Use FOCUS as a “safe place” to tell story
or as Dr. Levers commented in the group, FOCUS offers “authentic sanctuary.” (d)

Develop healthy micro communities using “street-wide interventions” and housing co-ops. (e) Employ a trauma-informed approach to development and healing. (f) Create professionals and paraprofessionals from within the community. Table 5 illustrates a synthesis of my major findings and proposed community interventions to begin the healing process in the Hill community.

**Synthesis of Findings (table 5)**

**Trauma Informed Community and Healing**

<table>
<thead>
<tr>
<th>Risk Factors/ barriers to Treatment</th>
<th>Major findings from focus groups</th>
<th>Community to address need</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stigma</td>
<td>Public Self Structural Label avoidance</td>
<td>“Trauma Informed Community Development Strategy” (TICDS) * Holistic approach to well-being *Community driven/community building</td>
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<tr>
<td>2. Chronic Community Violence</td>
<td>A.C.E. “Crime is normal” Drug trafficking Interpersonal violence “Hearing about”</td>
<td>*Destigmatize behavioral health *Mobile interventions (e.g., block interventions, Bioecological care plan, housing cooperative) *Resilience building</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Social Determinants</td>
<td>Lack of social and economic capital Unemployment Lack of access/opportunity</td>
<td>*Establish Professionals and Paraprofessionals (e.g., Behavior Health Community Organizers, Peer Support Specialists)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Racism</td>
<td>Individual Community Institutional Gentrification</td>
<td>*Create “safe place” to tell story *Build social and economic equity *Access to behavior health and primary care (i.e., FOCUS Pittsburgh Free Health Center)</td>
</tr>
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<td></td>
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<tr>
<td>5. Transgenerational/Historical Trauma</td>
<td>Racism/poverty “Mistrust &amp; distrust” “Vacant Esteem” Generational cycle of trauma responses</td>
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**Protective Factors**

Historical resilience of African Americans FOCUS Pittsburgh as “safe place”

Other local agencies Religion/spirituality
Initial feedback from the focus group about the vision included the following. The creation of professionals and paraprofessional (e.g., peer support specialist) from the community was strongly encouraged as it would build “trust” and improve “buy-in” from the community. These professional and paraprofessional would be able to “talk the talk and walk the walk” building rapport on the “streets.” This would help ensure community members “do not feel they are part of another research study,” but are being offered authentic care and support. Many community members have been “pushed out” of the neighborhood, because of a lack of housing equity and home ownership. The housing co-op will bring individuals back to the community as well a way to keep residents with no equity in the community. A continuing theme from the consultative workshop and at the follow-up focus group gathering was mistrust and distrust of community members or entities that they would “poach” the plan being discussed at the meeting. Participants wanted individuals to sign a confidentiality form to keep information from being leaked or stolen by another group in the community. At the conclusion of the focus group it was stated we would reconvene the group in few months after compiling all the additional information generated from the focus group and develop the plan further. The group met again on Sept. 18th, 2014 at FOCUS where the “trauma-informed development strategy: helping revitalize community by establishing and promoting healthy, healing micro-communities,” was presented. I will present a more detailed articulation of the strategy in the following discussion chapter.

Summary

In this chapter, I have presented my major findings and themes as well as the application of these findings for employment of community-based services to combat the
effects of community trauma and begin the healing process in the community. A consultative workshop was held in the community in April of 2014 and served three purposes. First, it raised the community’s consciousness about community trauma. Second, it allowed me to conduct community-based applied research, for which we can develop a community-driven behavior health plan. Third, it created the potential for additional contributions to the literature about community trauma and development in ethnic and racial urban neighborhoods. My research has suggested the Hill District is a trauma-informed community. A trauma-affected community has multidimensional origins that do not have one particular event as the cause, but rather, multiple layered contributing factors, which also have the potential to be barriers to seeking treatment. The five factors are stigma, chronic community violence, social determinants, racism, and transgenerational or historical trauma. The effects of stigma experienced in this community have created a culture of silence in which people are afraid to tell their stories of suffering and pain, which often can result in feelings of isolation, low self-esteem or vacant esteem, negative coping-mechanisms, and depression. Chronic community violence could be considered an epidemic in this community. Social determinants, which were identified in this investigation included poverty, unemployment, substandard housing or home ownership, below average schools, “street culture” (e.g., gangs, drug trafficking), and disparities in the criminal justice and healthcare systems. The experience of racism, whether “perceived” or not, is very real for the members of this community and is a major stressor contributing to community trauma through the community. The residuals of historical or transgenerational trauma are a part of everyday life and identity formation in this community.
These five factors contribute to the layering of trauma experienced by many in this community, which can result in low self-esteem or vacant esteem, anger, interpersonal difficulties, isolation, mistrust and distrust of others and institutions, negative coping mechanisms, cycles of trauma responses, and other physical and behavior health issues. Finally, I described the applied community-engaged research from the consultative workshop and two follow-up focus groups. A trauma-informed development strategy was developed to help revitalize the community by establishing and promoting healthy, healing micro-communities.
Chapter Five: Discussion

Introduction

Over 50 years ago, President John F. Kennedy signed the Community Mental Health Act (CMHA), which established comprehensive community mental health centers throughout the country. The Act deinstitutionalized the state hospital system, opening up federal money for community-based services. A growing body of research at the time concluded that mental illnesses could be treated more effectively in the community setting than in traditional psychiatric hospitals (Cheung & Snowden, 1990). The CMHA deemphasized the effectiveness of large clinical settings and systems in favor of community-based approaches. Although progress has been made for some, less progress has been made for predominantly African-American urban communities. Disparities in behavioral healthcare between African Americans and Caucasians have increased significantly since the 1990s, and social determinates such as poverty, access to resources, education, institutionalization, and housing status have influenced these disparities (Primm et al., 2010). Potential barriers to treatment have been identified on the individual, institutional, and cultural level in ethnic/racial minority populations. The need for authentic, comprehensive community-based behavioral services in communities similar to the Hill are needed to begin to address the disparities that exist in the current behavioral healthcare system (Ault-Brutus, 2012; Primm et al, 2010). My collaborative research project provided key stakeholders from the Hill with relevant information to plan and begin to implement community-based services.
**Purpose**

The primary purposes of this study are twofold: (1) To work with key stakeholders in the Hill District, through existing programming at FOCUS Pittsburgh, in identifying and defining social determinants that influence mental health disparities and in exploring the lived experiences of key stakeholders who are concerned with planning and implementing emergent community-based services; and, (2) To identify potential pathways or mechanisms for designing culturally appropriate mental health services for residents in a low-income urban community affected by community trauma. The pertinent information from the analysis helped the key stakeholders understand more fully how community trauma in an urban context affects social and individual recovery, as well as identify the protective and risk factors involved in the help-seeking processes. Finally, the research project was a response to a recent directive from President Obama, along with SAMHSA’s endorsement, to start a national conversation about behavioral health to reduce shame, stigma, and secrecy associated with mental illness (SAMHSA, 2013).

**Guiding Questions**

The guiding question for my project was, “How does community trauma affect social as well as individual recovery and the process of recovery in the community context?” To make the phenomena associated with the guiding question more explicit, I asked four subsidiary questions: (1) What is the lived experience of key stakeholders in an urban setting towards his/her lived time, lived space, lived body, and lived relation (van Manen, 1990)? (2) What are the protective and risk factors involved in the help-seeking processes? (3) What factors may contribute to community and individual
agency? and (4) What potential mechanisms can be identified that can assist in community trauma abatement or prevention programming?

**Review of the Literature and Methods**

I used the Rapid Assessment Process (RAP) for my research project. RAP has a strong documented track record for producing timely data that addresses public health problems. Rapid assessments have been used around the world, by such organizations as the W.H.O., U.N., and Doctors without Borders to study various public health issues. RAP was used to ground my research and add validity and reliability. In qualitative research, reliability and validity often are determined in terms of the rigor of triangulation, which involves a process of using multiple ways of verifying (Needles, et. al., 2003; Berg & Lune, 2012). I believe that my inquiry is strong, in this regard, as I have incorporated theoretical triangulation (by blending multiple compatible theories), methodological triangulation (by using multiple methods), triangulation of data (by employing multiple sources of data), and analytical triangulation (by applying multiple analytical strategies). The study utilized the consultative workshop method as an extension of focus groups, participant observation (PO), and participant action research (PAR). The consultative workshop brought together key stakeholders from the Hill community to explore community trauma and begin planning emergent community-based services. The consultative workshop generated rich naturalistic data by identifying pertinent information linked with phenomena associated with community trauma, such as underlying issues related to potential barriers to behavioral health treatment. These methods produced quick intervention recommendations for FOCUS.
To ground my study in theory, I used seven compatible theories. The seven theories that make up my theoretical framework are: (1) van Manen’s *Lifeworld Exsistentials* (1990); (2) Bronfenbrenner’s (1979, 2006) Bioecological Model of Human Development; (3) Historical Trauma Theory (e.g., Sotero, 2006); (4) Posttraumatic Slave Syndrome (DeGruy, 2005); (5) Social cognitive theory (Bandura, 2001); Six, Self-Determination Theory (Ryan & Decci, 2000) and Maslow’s Hierarchy of Needs Model (1971); and (7) Narrative Construction Meaning-Making Identity (e.g., Singer, 2004).

I reviewed the literature on the development of psychological trauma, several constructs and definitions of trauma, and the limitations of the PTSD construct. I detailed the literature on mental health disparities in ethnic/racial minority groups, specifically stigma, racism, and social determinants. In addition, the literature suggests that African Americans living in low SES urban environments are more likely to experience assaultive traumas and have higher rates of PTSD (Liebschutz et al., 2007; Alim et al., 2006; Breslau et al., 1998), but are often under-diagnosed (Magruder et al., 2005; Swartz et al., 2005). Finally, the literature calls for more applied community-based research.

This chapter I discuss the findings from my collaborative research project. Included in the discussion will be the five main themes/factors generated from my analysis of the data. The five themes/factors will be discussed within the context of the *lifeworld existentials* (van Manen, 1990) and ecological considerations. Also, I will include a summary of the protective factors and operationalize trauma-informed community in the context of the Hill. Next, I will describe the implications and applied nature of the research. Further, I will describe the limitations of the study and offer
opportunities for future research, contribution to the professional counselor literature, and generated hypotheses. I will conclude this chapter with a summary.

**Discussion of Findings**

My findings theorize multiple factors that are contributing to the idea of community trauma as reported by key stakeholders in the Hill community. The term “community trauma,” as referenced in the literature, is usually associated with a particular traumatic event(s), such as a hurricane, an industrial accident, war and genocide, mass shooting, or terrorism. My research suggests multidimensional origins that do not have one particular event as the cause, but rather, multiple layers of contributing factors, which also have the potential to be barriers to seeking treatment. Therefore, the term “trauma-informed community” is used here to describe more fully the lived experience of many in the Hill community. My exploratory research findings suggest five main contributing risk factors/themes, which inform community trauma in the Hill as well as the help-seeking process. The five factors/themes are stigma, chronic community violence, social determinants, racism, and transgenerational or historical trauma (Sotero, 2006; Heart & DeBruyn, 1990). These five factors/themes will be discussed in the context of the lifeworld existentials and an ecological perspective. In addition, I discuss protective factors, as identified from the focus groups; these included community non-profit organizations, historical resilience of African Americans, and spirituality/religious affiliation. The following paragraphs summarize my research findings.
Theme/Factor 1: Stigma

One of the most consistent themes and risk factors reported in all the focus groups was family, peer, and community disproval for seeking help, as well as a distrust of the behavioral healthcare system. Distrust in the behavior healthcare system reportedly originated from “bad experiences” where the individuals felt discriminated against and treated differently than their White counter parts. Key stakeholders experienced “public stigma, self-stigma, label avoidance, and structural stigma” (Corrigan & Ben-zeev, 2011). The most common form of stigma was public, which influenced the idea of label avoidance and self-stigma. The public stigma reported by many in the focus groups was influenced on the micro and macro-social levels. Examples of public stigma reported were associated churches, families, as well as friends and peer groups. The family system was reported as the most influential form of public stigma. Common expressions shared by many in the focus groups were the phrases, “what happens here stays here,” and “I would be disrespecting my family if I get help.” A cultural norm is instilled at a very young age that prohibits a child from going outside of the family and fosters a distrust of larger structural systems, such as CYFS and schools. The possible reason for the pervasive experiences of stigma by many in this community could be related to the effects of historical trauma (Sotero, 2006) or the idea of Posttraumatic Slave Syndrome (DeGruy, 2005). The effects of stigma experienced in this community have created a culture of silence, where people are afraid to tell their story of suffering and pain, which often results in feelings of isolation, low self-esteem or vacant esteem, negative coping-mechanism, and depression.
Theme/Factor 2: Chronic Community Violence

A predominant risk factors reported in all the focus groups was the experience of chronic community violence. Many reported adverse childhood experiences that were not addressed until they were adults. Some of the different forms of violence experienced were sexual abuse and assault, emotional and physical violence in the home, as well as violence outside the home in the community. As a result of the chronic nature of the violence experienced and “hearing about” (Horowitz, Weine, and Jekel, 1995) in the community or through the media, key stakeholders reported of the sense of numbing and normalization of violent experiences. The effect of chronic community violence has fostered feelings of hopelessness and powerlessness in the community. These feelings of hopelessness and powerlessness have contributed to low self-efficacy and lack of agency (Bandura, 2001).

Theme/Factor 3: Social Determinants

Social determinants are the complex economic systems and social structures that are considered responsible for most health inequities (Commission on Social Determinants of Health, 2008). Social determinants are formed by the distribution of money, power, and resources throughout local communities. The Hill, like many other urban racial/ethnic neighborhoods around the country, suffers from substandard housing and education, lower social and economic equity, higher unemployment rates, poverty, higher rates of incarceration, and access to resources. Social determinants identified from the focus groups include poverty, unemployment, substandard housing or home ownership, below average schools, “street culture” (e.g., gangs, drug trafficking), disparities in the criminal justice system, and the healthcare system. These social
determinants contribute to the stress on the community and add additional layers to the idea of a trauma-informed community.

**Theme/Factor 4: Racism**

Key stakeholders reported racism on the individual, community, and institutional level. On the individual level, participants shared stories of being followed by store personnel while shopping, or getting on an elevator with White women and watching them clasp their purses in fear and mistrust. Key stakeholders consistently reported their perspective that Pittsburgh is a racist city and that many of the neighborhoods are still segregated by color lines. At the institutional level, participants talked about being treated differently in the healthcare system and receiving different treatment protocols than their White counterparts. Another form of institutional racism raised in the focus groups was fear of and a lack of trust in law enforcement.

**Theme/Factor 5: Historical and Transgenerational Trauma**

Historical trauma theory posits that psychological and emotional scars from the trauma of slavery and other forms of extreme oppression are passed down through succeeding generations through physiological, environmental, and social pathways resulting in an intergenerational cycle of trauma responses (Sotero, 2006, p. 95). For many in the focus groups the residuals from slavery are a part of everyday life and contribute to identity formation. One profound statement by Ms. Holland summarizes the influence of historical and transgenerational trauma, she states, “we are born into trauma, we die in trauma, we live our lives in trauma, there is not an answer” (Focus group 3, session 2). The effects of slavery have not only been passed down through the generations of African Americans, but the slave/master dichotomy is still being enacted
in the social and economic systems of the U.S. van Manen’s lifeworld existentials will help illuminate more fully the lived experience of community trauma in this neighborhood.

**Lifeworld Existentials**

van Manen’s (1990) *Lifeworld Existentials* provides a sensitive methodological approach to understanding the subjective nature of key stakeholders’ experience of community trauma, as well as the attitudes and beliefs associated with behavioral healthcare. Phenomenological research attempts to get at the “essence” of a phenomenon by bringing the phenomenon into the light, describing ecologies, and revealing the “internal meaning structures” of the lived experience. van Manen states that hermeneutic phenomenological reflection research is “explicit in that it attempts to articulate, through the content and form of text, the structures of meaning embedded in lived experience” (p. 11). The four existential themes that guide the inquiry are “lived space, lived body, lived time, and lived other” (van Manen, 1990). Lived space is not only the physical space, but it is also how a person experiences his or her being in day-to-day activities. Lived body is an individual’s understanding of his or her physical presence in the world. Lived time is an individual’s biography. Lived other is an individual’s interaction with others or relationships that share space in his or her life. Although the lifeworld existentials are distinguished into four categories for the purpose of inquiry, the lifeworld existentials are intrinsically connected and can never be completely separated from each other.

**Lived Space (Spatiality).** van Manen contends that trying to articulate lived space is very difficult, because the lived experience of space is “largely pre-verbal” (p. 102). Most individuals do not frequently reflect on daily interactions with their
environment, making the lived experience of space more pre-reflective in nature where an emotion is often first experienced, which reflects a sense of self in the space. The feelings of fear, vulnerability, hopelessness, powerlessness, confinement, anxiety, and isolation convey the pre-reflective experience of the lived space of the Hill by key stakeholders. Mr. Banks’ statement, “The Hill is like jail,” describes an analogy for the lived space of the Hill and produces an immediate feeling. The statement reflects the feeling of being confined, isolated, and of having one’s autonomy and agency stripped away. Jail strips away individual rights afforded to most citizens and dictates the individual’s daily routine. The individual does not have the freedom to make decisions about day-to-day activities or imagine actualizing his or her full potential. If jail is an analogy for living in the Hill, feelings of being confined, vulnerable, and lacking agency can become part of the individual’s as well as the community’s identity. This identity has been shaped and formed by the experiences of the lived space as a jail. Jail becomes a metaphor for life resigned to living within the confines, culture, unpredictability, violence, subjugation, and radical isolation prescribed by the jail environment. In addition to the risk factors associated with the lived space of the Hill, the FOCUS space has become, in many respects, a protective factor in the community, as articulated by those who participated in the investigation.

FOCUS as a space offers sanctuary, safety, and opportunities for reconnection for many in the Hill. FOCUS transcends the esthetics of the Hill and becomes a safe place for people to tell their story and form authentic relationships. “I have been on my own since I was a child…I have nobody…that is why I come to FOCUS…I am here for the love” (Ms. Winter, focus group 3 session 3). FOCUS has created an environment where
an offer of a cup coffee becomes a vehicle for human connection and the possibility of healing and growth to begin to take place.

**Lived body (Corporality).** Lived body is an individual’s understanding of his or her physical presence in the world. An overwhelming majority of participants in the focus groups spoke about being Black and being discriminated against based on the color of their skin. Many participants reported not receiving the same treatment as their White counterparts or being misdiagnosed in the healthcare system. In addition to the pervasive experiences of racism, the effect of community trauma has influenced what DeGruy (2005) describes as “vacant esteem,” the belief that an individual as little or no worth. The idea that an individual has little or no worth, neither high nor low self-esteem, not only can lead to vacant esteem but a vacant sense of self. Further, vacant esteem can lead to behaviors and feelings that may hinder making and maintaining relationships, which can reinforce feelings of being disconnected from others. Feeling isolated and disconnected from others was commonly expressed in the focus groups. The following are examples of the lived body experiences expressed by key stakeholders. “I am tired of wearing Black! “I am in here, but, I want to come out, but there is so many layers of life, that are wrapped around that it takes time to get to…” (Ms. Mary, focus group 3, session 2). Or, as Ms. Carter states, “We are the walking wounded” (focus group 1, session 1).

The reality of “heard about” and experiences of chronic community violence has for many permanently activated the primal brain function of “fight, flight, or freeze.” As a result, many community members live in a constant state of survival, in which fight, flight, or freeze becomes their daily mode for living.
**Lived Time (Temporality).** Lived time is an individual’s biography. It is the past influencing the present and the future, as well as the present or future influencing the memory of the past. The past and future are not two distinct realms, but instead are embodied in the present. Trauma can leave a lasting effect on an individual that manifest in memories and can influence an individual’s self-concept. The experience of adverse childhood experiences (ACE) and the emotional, psychological, and physiological effects those experiences can have on an individual was an “aha” moment for many in the focus groups. The participants after hearing the presentation on the ACE study (Felitti, et al., 1998) identified with the results, as it provided a context for the distress many of the key stakeholders had experienced or witnessed in the community. Many of the key stakeholders reported multiple adverse childhood experiences. I hypothesize that the frequency of ACE reported in the focus groups results in part from the intergenerational cycle of trauma responses passed down through the generations (Sotero, 2006) and the effects of slavery’s “legacy of trauma” (DeGruy, 2005). Often this legacy is passed down through parenting styles. Many in the focus group reported violence in the home and negative labeling of children. It was reported that it was common for neighbors to “beat you” if you misbehaved. The legacy of trauma is not only passed down through families, but also has been passed down through the community (DeGruy, 2005). For many in this community, the lived reality of “trying to survive” is a legacy of trauma and can directly influence an individual’s and a community’s future potential and identity formation.

**Lived Other (Relationality).** Lived other is an individual’s interaction with others or relationships that share space in his or her life. Lived other brings to the forefront interpersonal themes and projections we make about others in our interactions
with them. Traumatic experiences can have profound effects on relationships and cause disconnection with others (Herman, 1992/1997). A common theme shared in all the focus groups was a distrust of institutions and mistrust of peers and family members. The mistrust reported from the participants’ not only stems from interpersonal traumas, but is also influenced by transgenerational trauma or historical trauma passed down through the generations. In addition, the mistrust of others is related to being stigmatized or fear of having your story shared around the neighborhood and of being judged. Participants in the focus groups all reported about negative labeling in their community, especially with children, whether it came from inside the family system or community, or from external forces such as in the media. The data suggests that healthy interpersonal relations are difficult to form, maintain, and often are strained, because of the negative labeling or judgment, cycle of trauma responses, and the residuals of historical trauma.

The summary of my findings, as described in Chapter 4, theorized that multiple factors are contributing to the idea of community trauma as experienced by key stakeholders in the Hill community. My research suggests a broader, multi-layered conceptualization of community trauma. Noting that the term community trauma does not fully describe the lived experience of key stakeholders in the Hill, I use the term “trauma-informed community.” The following section will describe and operationalize this term.

**Trauma-Informed Community**

I first heard the term “Trauma-informed community” several years ago when I was asked to be a part of the planning and participation of a community dialogue in the Hill around the idea of community trauma. Over the last 20 years, SAMHSA (July, 2014) has been researching and working on developing a *Trauma-Informed Approach* that can
be used across a variety of service sectors as a way to help resolve trauma related issues. SAMHSA reports that trauma researchers, practitioners, and survivors suggest that non-integrated trauma-specific interventions is insufficient to improve treatment outcomes or healing for trauma survivors. Trauma specific interventions primarily utilized in specialized clinical settings might only be effective for those who seek treatment, have access, and/or realize their physical or mental distress may be related to a traumatic experience. For many in the Hill, trauma and trauma responses have become normalized in the community, which has contributed to non-help-seeking processes. Identifying trauma-informed communities is important as an extension of the current paradigm shift in the healthcare delivery system to a trauma-informed approach. The following paragraphs will lay out a framework for viewing the Hill as a trauma-informed community.

Paul Abernathy, the Director of FOCUS Pittsburgh, shared with me the following framework for understanding community trauma in his community.

A shared experience of suffering that characterizes the personal experiences of many in the community. Chronic unemployment, crime, drugs, homelessness, hunger, abuse, poverty, and most profoundly brokenness and radical isolation have all created a culture informed first and foremost by trauma. For this reason, trauma is the foundation upon which the community worldview is laid (personal communication, July 2, 2013).

This framework makes explicit the lived experience of trauma and meaning making made in the context of the Hill community. The framework illuminates the complex interwoven web of systemic issues/variables influencing disparities in behavioral healthcare
treatment and the overall well-being for this urban community. This framework highlights the individual and collective experience of “suffering,” which has the potential to influence negative meaning-making processes in the self, family, and ultimately in the community. Thus, “trauma is the foundation upon which the community worldview is laid.”

This framework highlights “culture.” The context for culture used in this framework alludes not only to the experiences of many in the African American community, but a community culture “informed” by multidimensional layering of traumas. These layers of traumas are interrelated between the individual and community as a shared experience and expression of each. Included in these layers of traumas are types of trauma, lifeworld existentials, social determinants, and the residuals from transgenerational or historical trauma. Community trauma in this context is not only a singular event or events, but placed on a continuum of lived experiences of the past and present informing future beliefs about one’s potential and identity formation. An example of this would be Posttraumatic Slave Syndrome (DeGruy, 2005). As I quoted earlier in this chapter, a participant stated, “we are born into trauma, we die in trauma, and we live our lives in trauma…there is not an answer.” This community’s worldview is “informed” by the multidimensional layering of traumas, which can act as a conduit to the construction of a narrative based on negative views of the self, including lack of agency, vacant esteem, anger, fragmented families and communities. Ultimately, a trauma-informed community affects the psychological and physical well-being of the individual and the community.
My research suggests the term “community trauma” does not fully capture the multidimensionality of trauma experiences in this community, which can influence not only the individual’s subjective meaning (i.e., identity), but the community’s as well. Inserting the word “informed” between “trauma” and “community” situates the lived experience (i.e., *lifeworld existentials*) centrally (figuratively and literally) and implies the subjective and objective qualities are mediated between varying systems. The Merriam-Webster dictionary defines “inform” as; “to be or provide the essential quality of (something): to be very noticeable in (something).” The term community trauma often highlights the very noticeable to the observer, for example chronic violence, but does not make explicit the more implicit pervasive experiences of many in the Hill. For example, I spoke with Mr. Cole, a volunteer from FOCUS after a community event we attended together, at which powerful stories of pain, suffering, and redemption were collected from community members and recited into a collective themed narrative. Mr. Cole said, “I have lived in this community for a long time and I think I know this community pretty well, but I had no idea all of that was going on.” A trauma-informed community illuminates the complex web of variables present in the Hill environment that can influence a worldview and identity founded on layers of victimization that exist on an individual and community level and are passed down through the generations.

In Chapter 4, I provided my findings from my exploratory qualitative research project. The analysis of the data shows the connection between types of interpersonal traumas and environmental factors with the idea of a “trauma-informed community” as described through the lived experience of key stakeholders. I hypothesize that due to the collective and overt nature of multiple types of traumas experienced across the life span,
capturing the lived experience of trauma in the Hill is more fully understood from a community context. Individuals are “nested” within multiple ecologies and if the social context does not have access to basic resources for physiological and psychological needs, including safety and security, it can affect growth and motivation for individuals to reach their full potential or self-actualize (Ryan & Decci, 2000; Lynch & Cicchetti, 1998; Maslow, 1971). In low SES urban environments, the lack of access to these basic resources or needs, mixed with the residuals from historical trauma can contribute to the layering effect of traumas, resulting in a “collective traumatization” or a trauma-informed community (Horowitz, et al., 1995).

My findings suggest that this “collective traumatization” and “hearing about” traumatic experiences is commonly known to the Hill community. This public awareness of traumatic experiences is reported to be a major difference between predominantly White and Black neighborhoods. A statement by Mr. Abernathy will help to put this idea into context: “The difference between White communities and Black communities is that White communities don’t know it [trauma] is happening. Everyone in our community knows the trauma that is happening” (Focus group 1, session 2). Mr. Abernathy continues to share a story about a friend who has lost 40 friends. Mr. Abernathy is a veteran and related his friend’s losses to losing a whole platoon. He imagines the effect it would have on the sole survivor, as well as the effect it would have on the military, and on the country as a whole. Because traumas are known and happening in the Hill more frequently, the feeling in the Hill community is that the wider communities outside the Hill, as well as some in power positions, stay willfully ignorant. The result is an increased feeling of radical isolation and brokenness.
Ecological Perspective. Working from an ecological framework emphasizes the importance of identifying the protective and risk factors interacting on multiple environments influencing the lived experience of a community informed by trauma. In addition, recognizing and identifying the differences between many “White communities” and “Black urban communities” may lead to more divergent modes of thinking about trauma in the context of the community as a whole. “Our community our children are aware this [trauma] is happening. Creating a worldview shaped by this trauma… Indirect impact” (Mr. Abernathy). This statement makes explicit the difference between the lived spaces of predominantly Black urban neighborhoods and the lived space of predominantly White neighborhoods. Mr. Abernathy emphasizes that the community’s perceptions of trauma or what “is” or “is not” happening in their respective neighborhoods, has a direct influence on how individuals in the community generate a worldview of either safety, security, and control, or a worldview devoid of them (Courtois & Ford, 2013; van der Kolk, 2005; Singer, 2004). The trauma literature is consistent in demonstrating the mitigating qualities that environments can have against various types of traumas and meaning-making, that is, those in which an individual feels safe and secure, has some degree of control, and develops healthy attachments (Park, 2010; van der Kolk, 2005; Singer, 2004). Also, the indirect impact of “hearing about” (Horowitz, et al., 1995) can perpetuate views about their community as to whether or not the means are available in the community to keep the residents safe and secure.

Lynch and Cicchetti (1998) propose in their ecological-transactional model that an individual is “nested” in multiple levels or environments with varying degrees of proximity to the individual. They posit that transactions take place between the individual
and multiple ecologies that are not unidirectional but bidirectional or multidirectional. Taking this approach in viewing the individual as “nested,” postulates that not only do multiple environments influence individual identity formation, but also that the individual can influence the environment. It would not be a theoretical leap to imagine linking individuals’ experiences of complex trauma or “compounded trauma” to a collective “identity of trauma” that influences and is influenced by multiple ecologies. In other words, it would require making a paradigm shift from focusing interventions solely upon individuals to focusing interventions on the collective identity of trauma expressed in this community. This shift would ultimately direct the primary importance of interventions at the environment.

Protective Factors

Protective factors expressed during the focus groups included historical resilience of African Americans, existing community-based services, and reliance on God or a higher power. Many in the focus groups identified FOCUS as a community-based organization that offered a “safe place” to receive assistance and to connect with other community members. FOCUS was identified as an “authentic sanctuary,” a community driven organization that “reflects the neighborhood,” and is “truly” serving the community. FOCUS acts in many respects as a “proxy” agency in the community (Bandura, 2001). Other agencies and programs identified as protective factors included Saturday schools for youth to learn about African American history and learning academies that teach youth leadership skills. The historical resilience of African Americans related to the idea of generations enduring slavery, Jim Crow laws, segregation, and “we are still standing.” Even though mistrust and distrust of some
current pastors and local churches was reported, a belief in God or a higher power was integral and identified in all three focus groups as a protective factor.

**Implications**

My research project addressed a real need for FOCUS and the Hill community. The consultative workshop method (Levers, 2003) is a form of participant action research (PAR). From conception to the end, my research was collaborative and community-driven. The data generation and findings happened quickly with the intention for informing the planning and application of community-based services. The final session of the consultative workshop in many ways was a “plea” of some sort, for the community to “come together” and develop a community-driven plan to address community trauma, and ultimately begin the healing process. My project was intentionally designed to provide pertinent information for the development of community-services. “Trauma-informed community development strategy: helping revitalize community by establishing and promoting healthy, healing micro-communities,” was the name given to the strategy by FOCUS Pittsburgh. The following will describe the development strategy.

**Trauma-Informed Community Development Strategy**

There are six major points that guided the development of the FOCUS Pittsburgh trauma-informed community development strategy (TICDS). The six points include: (1) The plan will use a community-driven behavior health method using holistic approach to well-being; (2) A medical safety net has already been provided through the FOCUS Pittsburgh Free Health Center (FPFHC) in the community, which addresses access issues; (3) FOCUS acts as a “proxy agency” (Bandura, 2001) providing a “safe place” for narrative sharing to begin and for consciousness raising to occur; (4) The community can
begin to build and develop healthy micro communities using “block interventions” and housing co-ops; (5) The community can employ a trauma-informed approach to development and healing; and (6) The community can identify and nurture creation of professionals and paraprofessionals from within the community to implement the strategy. The TICDS attempt to address stigma, chronic community violence, racism, social determinants, transgenerational and historical trauma, and build on the existing protective factors. The focus of the strategy is to redefine urban development for trauma-informed communities. This approach is a counter to the enduring effects of urban renewal in the 1950s and City council member George Evans’ statement; “approximately 90 percent of the buildings in the area [lower Hill] are sub-standard and have outlived their usefulness, and so there would be no social loss if they were all destroyed” (From Greater Pittsburgh, 1943). The TICDS redefines urban (re)development from viewing development as purely “brick and mortar,” to an investment in “human development” (personal communication, Mr. Abernathy). From these six points, the FOCUS TICDS was developed.

There are three main components to the TICDS: (1) Creating Behavior Health Community Organizers (BHCOs); (2) Block Interventions; and (3) Creating Housing Co-ops. In addition to the three components of the TICDS an assessment tool is being created to assess the application of the strategy and overall well-being of individuals and community involved in the intervention. The assessment tool is called the, “Well-being, Relational, Stability, and Competency Index” (WRSC-I). WRSC-I is being developed, collaborately, between FOCUS Pittsburgh staff and volunteers and graduate students from the University of Pittsburgh. This index will measure well-being by assessing
physical health, psychological health, social health, spiritual health, relational stability, and competency of each individual. These measures will then be factored together to produce a WRSC-I score. The objective of the Index will be to implement appropriate block interventions to improve the WRSC-I for each participating individual, and consequently increasing the overall WRSC-I score of each family and the entire micro-community. “The hypothesis is that by improving the primary measure, secondary measures will follow suit and improve. The secondary measures include healthcare compliance, unemployment, educational performance, financial competency, and housing improvement” (BHCO meeting notes). Our assumption is that improvements on the primary and secondary measures will demonstrate an overall success of the TICDS. I am currently working with FOCUS to apply for major grants to implement the TICDS pilot program in the fall of 2015. The following paragraphs will describe in more detail each of the three components of the TICDS.

**Behavior Health Community Organizer (BHCO):** For this strategy to be authentically community driven, the BHCOs will need to be selected from the Hill. Key stakeholders reported that professionals and paraprofessionals will need to be able to “talk the talk and walk the walk,” building rapport on the “streets.” This would help ensure that community members “do not feel they are part of another research study,” but are being offered authentic care and support. In addition, a BHCO who is from the neighborhood would build “trust” and improve “buy in” from the community. I am currently working with a key stakeholder to develop a training program for the BHCO. Initially the BHCO will foster building community with a sense of healing and building
micro-communities that have an understanding of health and well-being. The second component is to establish micro-communities through block interventions.

**Block Intervention:** The BHCO will be the organizer for the block interventions. The block intervention will attempt to establish healthy micro-communities as a first step in defragmenting and reconnecting community members. Block interventions will employ a strength-based approach. The Block intervention strategy focuses on human development. The following is the working plan for the block intervention.

1. **Probing the street** – identifying leaders and individuals known by the organization on the street. Also, identifying strengths on the street such as resilience, spirit, upward mobility, home ownership, interpersonal skills and leadership.

2. **Researching the street** – collecting data points from a variety of sources in order to gain a focus for the intervention and commitments from the participants on the street.

3. **Conducting Interviews** – using a one-on-one format not only to learn the needs of each member, household and of the general block, but also to motivate the participants on the street to take ownership of their own intervention.

4. **Gaining Commitments** – in order for the block interventions to be successful, all the members of the block must be 100% committed to the efforts.

5. **Hosting a Block Consultative Workshop** – this workshop will draw out the block perspective on trauma and will draw out any other problems
within the block. Before commencement of the consultative workshop, the participants will determine their own benchmarks for the intervention and for their healing process.

6. **Implementing Intervention Strategies** – a comprehensive approach to improving health and overall well-being will be taken with the block interventions and will address topics such as food insecurity, health, unemployment, income, debt, street conditions, vacant lots and education.

7. **Evaluating and Re-Evaluating** - trauma leads to disconnection with the community and with other individuals. Therefore, healing can only be accomplished through reconnection. The evaluation process will not only include tracking the street-determined benchmarks, but will also include an initial evaluation and frequent re-evaluations of the individual’s ability to connect to other human beings through the WRSC-I.

8. **Paying It Forward** – individuals from the first block will be trained to be ambassadors of the program in order to draw out and recruit more individuals and blocks for the second block intervention (BHCO meeting notes).

The block intervention plan uses a consultative workshop method, facilitated by the BHCO and local partners. From the workshop the block will build a *bio-ecological care plan*, which will include a comprehensive well-being improvement plan for each family. This bio-ecological care plan will be developed from a trauma-informed approach to care, providing a holistic methodology to health and well-being. The hypothesis is this
holistic approach will help to change the “culture of the street” to culture of healing and thriving.

**Housing Co-op:** Many in the Hill live a transient lifestyle. In response to this phenomenon, a micro-community could be collected and guided through a process to facilitate the development of a low-equity housing co-op to alleviate the transient lifestyle. Many community members are starting to use the FPFHC and are beginning to improve their health. In addition, through other established programs at FOCUS, these individuals are gaining employment and learning new skills and healthier coping mechanism to heal from their trauma history. However, housing for many is a major issue. Since the consultative workshop, a small group of individuals started to come together at FOCUS to work on building an intentional community with a focus on stability and healing. For many, the housing co-op will be the first time anyone in his or her family will have had housing equity.

**Redefining Urban Development**

In many respects the TICDS is a model for redefining urban development by incorporating a trauma-informed approach. For urban communities with similar social and environmental characteristics as the Hill are at risk for urban (re)development that are solely based on brick and mortar improvements. Traditional urban redevelopment can often lead to gentrification or re-gentrification of the neighborhood (Lees, 2008), rather than investing in human development and healing trauma-informed communities. This community driven approach to development has the potential to begin to heal the residual scars of historical traumas, reduce behavior health disparities in racial/ethnic minority urban populations, and build resilience. Resilience is defined in terms of the ability of an
individual “in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event such as the death of a close relation or a violent or life-threatening situation to maintain relatively stable, healthy levels of psychological and physical functioning” (Bonanno, 2004, p. 20). In The Resilience Dividend: Being strong in a world where things go wrong, Judith Robin (2014) lays out framework for developing resilience in individuals, communities, and in organizations. She states that, “[B]uilding resilience is one of the most urgent social and economic issue…of the 21st century” (Rodin, 2014, p. 4). The premise of her book suggests that individuals, communities, and organizations can build resilience to mitigate the effects from stresses and unexpected adverse experiences. The more resilience building that occurs, the more an individual, community, or organization has the ability to create or take advantage of an adverse experience and turn it into an opportunity. She calls this process the “resilience dividend.” The TICDS has the possibility to build resilience in the community and the potential in the future to see the benefits of the “resilience dividend.”

**Limitations**

This qualitative inquiry used Rapid Assessment Process (RAP). RAP has a strong documented track record for producing timely data that addresses public health problems. I used RAP to ground my research and add validity and reliability. Reliability and validity is maintained by triangulation of my findings by using multiple methods (Needles, et. al., 2003; Berg & Lune, 2012). The study utilized a consultative workshop method an extension of focus groups, PO, and PAR. These methods produced quick intervention recommendations for the community. In addition, this study employed multiple theoretical frameworks. Berg and Lune (2012) suggest novice researchers use
multiple methods in a single investigation. In addition, using multiple theoretical perspectives, multiple data collection methods, and multiple analysis techniques increases triangulation and depth of a study (Denzin, 2010). The data collected was summarized into a non-jargon fashion, making it accessible and easily understood by the community. I presented my results to the key stakeholders at the follow-up focus group gathering about a month after data collection. Participants were in agreement with the findings; no discrepancies were voiced; and the results reflected the lived experience of the key stakeholders present at the consultative workshop.

There are some limitations in the project as it stands. The first limitation is that this study is not generalizable. The project is exploratory research, and its intention was to generate naturalistic data for the purpose of FOCUS to develop community-based services.

Another potential limitation is the potential for the researcher’s personal biases to influence the analysis of the data (Patton, 2002). In a qualitative research project such as this, I am the primary instrument and play an intrinsic role in the design, data collection and analysis (Glesne, 2011). In participant action research complete objectivity is not the aim of the research method. I used reflective journaling in the attempt to check my own assumptions and maintain a level of objectivity.

**Future Research Considerations**

Questions and opportunities for future research regarding the concept of trauma-informed communities have evolved throughout the process of this study. The literature on trauma increasingly uses ecological perspectives as a framework for gaining insight into psychological trauma, community trauma, and the development of culturally
sensitive counseling intervention strategies (Levers, 2012; Lynch, & Cicchetti, 1998; Herman, 1992/1997; Overstreet, & Mazza, 2003). The following paragraphs present four areas of inquiry for future research considerations and the associated questions generated from my research.

The first topic in need of further inquiry that emerged from my project is the generalizability of the consultative workshop method in trauma-informed communities throughout the United States. Potential questions that need further investigation include: (a) Can the consultative workshop method be applied in neighborhoods that are not homogenous? For example, East Liberty, a historically Black neighborhood east of the City of Pittsburgh, is experiencing gentrification. In order to address issues such as higher rent, loss of community identity, and an influx of White middle class residents, could this model work in a heterogeneous community where issues of race and power are more present yet conspicuously silent?; and (b) How does geography play a role? For example, would this method work in Detroit, Michigan or Chicago, Illinois? What influence(s), if any, would historical difference between Southern states and “rust belt” cities have on the consultative method, such as Pittsburgh, Pennsylvania versus Birmingham, Alabama? In addition, what would be the difference among urban, suburban, and rural communities in their application of the consultative workshop method?

The second line of inquiry that needs further exploration is the concept of a trauma-informed community. Two additional questions are suggested for this investigation. One, how can we complicate and better understand the concept of “trauma-informed community?” Two, how would other communities, such as those mentioned above, collectively define the lived experience of “trauma-informed community?” These
two lines of inquiry call for more qualitative research. Additional qualitative research revolving around these questions would generate more thorough explanations and provide scholars and practitioners alike with a more comprehensive framework.

The Third line of investigation is related to DeGruy’s (2005) idea of “vacant esteem.” Vacant esteem is a behavioral pattern associated with the concept of PTSS. Two questions generated from my research and DeGruy’s idea of vacant esteem are: (a) Will building social and economic equity as part of the “trauma-informed development strategy” have the effect of building esteem or moving it from “vacant” to present?; and (b) what is the effectiveness of employing block interventions and co-ops in addressing vacant esteem?

Finally, the TICDS is only recently being implemented in the Hill and many questions need to be answered and explored. This paragraph will suggest questions related to the TICDS proposed in the community. What are the outcomes related to the TICDS? What will be obstacles in implementing the TICDS in the community? As stated earlier in this chapter, the WRSC-I is being created to measure well-being. The tool will measure well-being by assessing physical health, psychological health, social health, spiritual health, relational stability, and competency of each individual. The reliability and validity of the index will need to be tested. In addition, the hypothesis stated earlier in this chapter, “By improving the primary measure, secondary measures will follow suit and improve. The secondary measures include healthcare compliance, unemployment, educational performance, financial competency, and housing improvement,” has yet to be tested. Finally, what will be the effectiveness of the BHCO in employing the TICDS and how will the BHCO be perceived in the community?
**Contribution to the Professional Literature**

The guiding question the project sought to understand more fully was the lived experience of community trauma and the effect it may have on social and individual recovery in the community context. The study highlights the “nested” quality of the individual in the context of multiple systems in the community and provided pertinent information to help guide community-based services in the Hill. My project will add to the professional literature in three main areas: mental health disparities, social justice, and trauma-informed approaches.

**Mental Health Disparities**

My study is a response to Snowden and Yamada’s (2005) call for community-based research that “observed the help-seeking processes at a higher level of detail,” and the Primm et al., (2010) appeal for research focusing on social determinants that contribute to disparities between African Americans and Caucasians. My research adds further description of the lived experience (i.e., *Lifeworld Existentials*) of trauma from a community context, identifying protective and risk factors, and assessing community needs for planning and implementing community based services. My research findings are consistent with Prim et al., (2010) who found barriers to treatment exist at the individual, institutional, and cultural levels in ethnic/racial minority populations (2010). My findings suggest that an institutional (i.e., mental healthcare system, University) intervention would be ineffective in this community. My research suggests that community-driven micro-interventions, such as the TICDS, are more consistent with the needs of the community and offer a greater possibility for healing in a trauma-informed community.
Social Justice Perspective

The American Counseling Association (ACA) Code of Ethics (2014) states, “Counselors advocate to promote change at the individual, group, institutional and societal levels that improve the quality of life for individuals and groups and remove potential barriers to the provision of access of appropriate services being offered” (Section C). The ACA Code of Ethics calls for counselors to be informed agents of change. Not only agents of change for individual clients who show up in our offices, but also working to change unjust or systemic issues at the individual, group, institutional, and societal levels that can act as barriers to services. My collaborative project has identified barriers and risk factors to treatment for the Hill community. My research is a useful case study for graduate students, scholars, and professional counselors of applied community-engaged research. It proposes a culturally sensitive community-driven behavioral health initiative that has the potential to lessen mental health disparities, build social and economic equity, and increase well-being for a trauma-informed community. The TICDS attempts to address the injustices related to social determinants, stigma, and reduce adverse experiences in a trauma-informed community.

Trauma-Informed Approach

My study describes a new model for addressing the needs of a racial/ethnic trauma-informed community. My project attempts to describe in greater detail the lived experience of psychological trauma and the idea of a trauma-informed community, such as the Hill. This study has described the multidimensional and layering of traumas experienced by many in the Hill and the influence of a worldview founded on trauma can have on identity formation. The TICDS is a multidimensional strategy created to address
the harmful effects associated with a trauma-informed community. The TICDS adds to the current trend of “integrated care” and “trauma-informed approaches,” (SAMHSA, July 2014) by adding community development to an integrated and trauma-informed approach. This approach integrates individual and community well-being from an ecological and motivational theoretical context.

Summary

Pittsburgh’s Hill District is an extraordinary African American community. In January of 2013, I was invited to be on a panel and planning committee to create an intentional conversation around the topic of community trauma in the Hill. This conversation was part of a lecture series sponsored by Duquesne University. Little did I know, at the time, that this chance encounter with the Director of FOCUS would be the catalyst for my action research project. The guiding question for my research project is, “How does community trauma affect social as well as individual recovery and the process of recovery in the community context? To answer this question I designed a multi-method applied research study, which is appropriated for this line of inquiry. I used RAP to ground my research and add validity and reliability. The study utilized the consultative workshop method, PO, and PAR. In addition, this study employed multiple theoretical frameworks. My research project addressed a real need for FOCUS and the Hill community. My research from beginning was collaborative and community driven. The data generation and findings happened quickly with the intention for informing the planning and application of community-based services. This approach to the research project lead to a “horizontal rather than a vertical pedagogical model,” creating a non-
hierarchical intentional design and space for shared knowledge building, for the purpose of creating community-based services.

The primary purposes of this study was to work with key stakeholders in the Hill, through existing programing at FOCUS, in identifying social determinants that influence health disparities. I also explored the lived experience of key stakeholders planning and implementing emerging community-based services. I used van Manen’s hermeneutic phenomenological reflection approach to explore the lived experience of key stakeholders. In addition, I identified pathways for designing culturally appropriate behavior health services in the Hill. The pertinent information from the analysis helped the key stakeholders understand more fully how community trauma in an urban context affects social and individual recovery, as well as identified the protective and risk factors involved in the help-seeking processes. This study added depth, resource knowledge, and helped guide the development of community based-services in a meaningful ways.

This study illustrates how essential it is to understand how people impact place and place impacts people. Over the last 40 years, there has been an increase in research exploring the interplay between the environment and the individual or group identity and development through the lifespan (Bronfenbrenner, 1979/1994; Lynch & Cicchetti, 1998; Overstreeet, 2003). Bronfenbrenner’s Bioecological Model posits that characteristics of the individual, “function both as an indirect producer and product of the environment” (Bronfenbrenner & Morris, 2006, p. 798). The environment can have a direct impact on an individual’s development and identity formation, as well as their overall well-being. The research helped key stakeholders’ recognize that individuals are “nested” in multiple ecologies and the bidirectional nature of interactions between individual and the
environment, has led to the emergence of the trauma-informed community development strategy.

This study describes a new model for addressing the needs of a racial/ethnic trauma-informed community. Adding to the current trend of “integrated care” and “trauma-informed approaches,” the idea of community development was integrated into a trauma-informed approach. This approach integrates the individual and community well-being by suggesting a trauma-informed community development strategy. This strategy seeks to redefine traditional urban development based on brick and mortar building to urban development based on “human development.” The goal of this initiative is to establish and promote healthy, healing micro communities. This strategy attempts to address the injustices related to social determinants, stigma, and reduce adverse experiences in a trauma-informed community and begin the healing process in the community.
References


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Primm, A. B., Vasquez, M. J., Mays, R. A., Sammons- Posey, D., McKnight-Eily, L. R., Presley-Cantrell, L. R., ... & Perry, G. S. (2010). The role of public health in addressing racial and ethnic disparities in mental health and mental illness. *Preventing Chronic Disease, 7*(1).


doi:10.1037/a0030054


physical and mental health socio-economic status, stress and discrimination.

*Journal of Health Psychology, 2(3), 335-351.*
Appendix A: Research Design Concept Map #1

- **Guiding question:**
  - What are the lived experiences of Hill residents' help-seeking processes or non-help seeking processes?
- **Subsidiary questions**
  - From theoretical framework

- **Qualitative methods**
  - Multi-method study (RAP)
  - Focus groups
  - Participant observation
  - Key informant interviews
  - Participant actions research
  - Case Study

- **Qualitative methods**

  1. Focus Groups
  2. Consultative Workshop Method
  3. Key informant interviews

- **Key issues**
  1. "Community trauma"
  2. Potential barriers to care
  3. Attitudes/behaviors about seeking treatment

- **Theoretical framework**
  - Self-Determination Theory (Ryan & Deci)
  - Perceived self-efficacy (Bandura)
  - Historical Trauma theory
  - Restorative Justice framework
  - Phenomenology and Existentialism
  - Narrative meaning construction

- **Literature review**
  - Inconsistent results
  - A need for community-based research
  - Identifying "malleable" barriers that explain racial disparities in current healthcare system
  - Illuminate and parse out the lived experience of Hill residents' perceptions of barriers to mental health treatment.
Appendix B: Consultative Workshop Agenda

Consultative workshop

Exploring Community Trauma: Planning Emergent Community-Based Services

FOCUS Pittsburgh

April 26, 2014

10 am – 4 pm

Session #1 10:00 am – 10:15 am
Introduction to the Bioecological Model of Human Development
(Intro by Dr. Lisa Lopez-Levers; Presentation by Jayna Bonfini)

Focus Group questions: 10:20 am - 11:10 am
- What is your response to what the speaker discussed?
- How does the information apply to the Hill?
- What are the protective factors involved in the help-seeking processes on the Microsystem, Ecosystem, Macrosystem, and Chronosystem?
- What are the risk factors involved in the help-seeking processes on the Microsystem, Ecosystem, Macrosystem, and Chronosystem?
- How do you think this needs to be addressed?

Session #2 11:20 am – 11:35 am
Defining trauma/Community trauma (Matt Walsh)

Focus Group questions: 11:40 am – 12:30 pm
- What is your response to what the speaker discussed?
- How does the information apply to the Hill?
- How would you define “community trauma?”
- What may influence or perpetuate community trauma using the Bioecological map?
- Using the Bioecological map what are the assets of the community in relation to addressing community trauma?
- Using the Bioecological map what are the needs of this community in relation to addressing community trauma?

Lunch 12:30 pm – 1:30 pm

Session #3 1:30 pm – 1:45 pm
Introduction to the ACE Study (Demond Bledsoe)

Focus Group questions: 1:50 pm – 2:40 pm
- What is your response to what the speaker discussed?
- How does the information apply to the Hill?
- Using the Bioecological map what are the main problems with this in the Hill?
- What are the attitudes towards mental health? Treatment?
- Using the Bioecological map, what may influence these attitudes?
- Using the Bioecological map, what are potential barriers to treatment?
Session #4  2:50 pm – 4 pm
Healing and Wrap-up (Assets and Needs Mapping) (Dr. Levers)

Focus Group questions:
  o What potential mechanisms can be identified that can assist in community trauma abatement or prevention programming?
  o How can people in the Hill community begin to heal?
  o Major concern, Major assets, major needs.
Appendix C: Bioecological Model Session 1 Power point

Bronfenbrenner’s Bioecological Model Consultative Workshop April 26, 2014

Bioecological Model

• Urie Bronfenbrenner (1974): Reaction to the restricted scope of most developmental psychologists.

• In order to understand human development, or the influence of trauma responses, one must consider the ENTIRE bioecological system in which growth occurs, including:
  • Microsystem
  • Mesosystem
  • Exosystem
  • Macrosystem
  • Chronosystem

Microsystem

• 1st tier: Immediate relationships (e.g., parent and child)
  • Intimate social and immediate physical environmental setting (home/family; school; peer group)
  • **Proximal processes** – interaction patterns within the microsystem
  • Healthy microsystems will enhance learning and development
  • Poor relationships can lead to information-poor and exploration-inhibiting microsystems

• NOTE: Microsystems can change as the individual changes, such as when a child goes to school.

Proximal Processes

• **Proximal processes** – energy transfer between individual (developing human) and immediate environment (be it persons, objects, symbols, etc.), in both directions;
  • Engines of Development
  • **Genotypes** are translated into **phenotypes**
    • Genetics x Environment
• Major outcomes based on proximal processes:
  • Competence – acquisition and development of knowledge, skill, or ability in any domain (intellectual, physical, motivational, socioemotional, artistic, etc.)
  • Dysfunction – difficulties in maintaining control and integration of behavior across situations and domains

Mesosystem

• 2nd tier: Interaction or links between several Microsystems
  • looks at the individual roles one plays in Microsystems in terms of their interactions with each other
    • one can be a son, a sister, a friend, a teammate;
    • having different roles in different contexts

• Example: If the links between the family microsystem and the school system breakdown, often students are worse off in school academically and show less initiative and independence, whereas in families where the family and school share mutual communication systems, the child does better in the same areas.

Mesosystem (cont.)

Areas of problems or risks within the mesosystem:

• **Impoverished mesosystem** – few or no meaningful linkages between existing Microsystems.
  • Individual is compartmentalized; no continuity between Microsystems (e.g. parents who don’t know the friends of their children).

• **Divergent values within mesosystem** – lack of congruency among Microsystems
  • Family condemns drug use, while friends condone

Exosystem

• Exosystem can impoverish or enrich the quality of the micro and mesosystems
• 3rd tier: larger community; neighborhood; local laws; (school boards – cut funding for school lunches)
• Individual has no direct influence

• Example: A parent’s stressful work environment or lack of employment (an exosystem) can affect a child’s home life (microsystem) and the interaction...
with other Microsystems (mesosystem). The parent may become less involved in the child's other Microsystems leading to an impoverished mesosystem.

Macrosystem

- 4th tier: Society/cultural norms; societal blueprint; public policy
  - Example: Social customs, Fashion
- Definitions of appropriate and inappropriate behavior

Chronosystem

- Chronosystem takes into account the constancy or change over time
- Time is continuous and not restricted to glimpses
  - Measurements of one’s IQ in 1990 and then again in 2000 does not take into consideration what or how those ten years have changed or effected the person
  - Different life experiences and life events, which can be external like entering school, divorce, experiencing violence, etc. or can be internal like puberty, severe illness, etc.
Appendix D: Community Trauma Session 2 PowerPoint

Exploring Community Trauma
Consultative Workshop
FOCUS Pittsburgh
April 26, 2014
Definition of Trauma

- Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. (SAMHSA, 2012, Part one: Defining trauma, para. 1)

Shattered
“Assumptive World”

- Traumatic events can destroy an individual’s understanding of his/her assumptive world (Janoff-Bulman, 1992)

- Trauma can alter the very existence and meaning that an individual gives to his or her life
  - Existential influences can hinder an individual’s ability to trust, hope, or care for his or herself or others, resulting in a disconnect between an individual’s perceived sense of self as well as relationships with others.

UNDERstanding Trauma

- Individuals who have experienced (a) traumatic event(s) are not focused on clinical aspects of their symptoms—they want relief from their suffering!
  - What is unseen and unheard?
  - Heal or cure?

- Mental, emotional, existential, and physical suffering can affect people in a variety of negative ways
  - Examples: personality changes, health status or the ability to function on multiple levels
  - Suffering as transformative
    Chronic Community Violence

- Common traumatic experiences in urban settings tend to be assultive traumas (e.g.,
sexual assault, friends/family murdered) leading to greater risk of symptoms of PTSD (Breslau et al., 1998).

- Alim, Graves et al., in their study of 617 African Americans, found a 65% rate of lifetime trauma exposure and a 33% rate of PTSD. Also, the research indicates that all too often PTSD is under-diagnosed and untreated (Magruder et al., 2005; Swartz et al., 2005).

- “compounded community trauma”
  - Horowitz, Weine, and Jekel (1995) study of urban female adolescents found the young women experienced a mean of 28 violent events.

Trauma as a Systemic Issue

- An individual or group experience(s) of trauma is always placed and interpreted within multiple systems (i.e., Bio-ecological model)
  - Holistic approach to trauma or “trauma informed”
  - When treating only the deviant behavior and not the source of the symptoms, the mental health system can become another source of abuse and can re-traumatize the individual.

Cultural Dimension

- Culture can shape how people view trauma and suffering
  - Culture can help with processing and expressing grief and suffering through rites and rituals (e.g., spirituals, religion, spirituality).

- Culture influences how individuals make meaning.
  - Diagnostic criteria can be inadequate depending on the cultural understanding of the illness and pathways to healing.

Social Justice Dimension

- Historical trauma theory or transgenerational trauma
  - Key feature of historical trauma theory is that the psychological and emotional consequences of the trauma experience are transmitted to subsequent generations through physiological, environmental and social pathways resulting in an intergenerational cycle of trauma response
  - The effects of a traumatic event can be intensified and worsened when the traumatized person also has cause to feel that he or she has been betrayed by the
very social community that should be extending assistance.

Community Trauma

• “A shared experience of suffering that characterizes the personal experiences of many in the community. Chronic unemployment, crime, drugs, homelessness, hunger, abuse, poverty, and most profoundly brokenness and radical isolation have all created a culture informed first and foremost by trauma. For this reason, trauma is the foundation upon which the community worldview is laid” (P. Abernathy).
Appendix E: ACE Study Session 3 PowerPoint

Trauma
Why should we care? What’s the big deal?
   The Literature suggests…

• The Adverse Childhood Experiences (ACE) Study is a landmark study that is designed to assess the relationship between factors determined to be “Adverse Childhood Experiences” and health outcomes later in life

• The study began after researchers working with populations attempting to lose weight noticed that the highest drop out rate was among those who were successfully losing weight

• It is a longitudinal study that has a population of over 17,000 adults living in the United States
   Ace study (Adverse Child, 2005/2008)
   Ace study (Adverse Child, 2005/2008)
   Ace study (Adverse Child, 2005/2008)
   Ace study (Adverse Child, 2005/2008)
   The Literature Suggests…

• The study found that nearly two-thirds of all respondents had at least one adverse childhood experience

• Over 12% of the respondents had 4 or more adverse childhood experiences

• There was a relationship that is described as strong and graded between the number of adverse childhood experiences and many risk factors that affect either or both quality of life and life expectancy

• Risk factors include alcoholism, COPD, depression, drug use, liver disease, intimate partner violence, sexually transmitted diseases, smoking and suicide attempts
Appendix F: Summary Session PowerPoint

*Healing*

26 April 2014

FOCUS Pittsburgh
Duquesne University
Lisa Lopez Levers, Ph.D.

**Trauma Affects Us on Multiple Levels:**
- Personal
- Physical
- Emotional/Psychological
- Spiritual
- Relational
- Social
- Cultural

- Bronfenbrenner’s Bio Ecological Model
- How can we begin to think about HEALING—personal recovery and community healing—in the Hill District?
  - Identifying Risks
  - Identifying Protective Factors
  - Enhancing and Constructing Protective Factors
  - Creating Resilience

- Healing
- Stages of Recovery
  - Establishing Safety
  - Reconstructing the Trauma Story
  - Reconnecting with Ordinary Life

- From: *Trauma and Recovery*, by Judith Lewis Herman
- Stage I: Establishing Safety
  - Naming the Problem
  - Restoring Control
  - Establishing a Safe Environment
  - Completing the First Stage

- Stage II: Reconstructing the Trauma Story
  - Remembering
  - Transforming Traumatic Memory
Mourning/Grieving Traumatic Loss

- **Stage III: Reconnecting with Ordinary Life**
  - Learning to Fight (or not Fight) Fair
  - Reconciling with Oneself
  - Reconnecting with Others
  - Taking Constructive Action
  - Continuing the Healing Process

- **Healing**
  - We need to heal ourselves.
  - We need to heal our families.
  - We need to heal our communities.

- **From: Post Traumatic Slave Syndrome: America’s Legacy of Enduring Injury and Healing,**
  - By: Joy DeGruy
Appendix G: Picture Example of Summary Session with Facilitator Notes
Appendix H: Focus Group Example of Bioecological Model with Post-it Notes
Appendix I: First Follow-Up Focus Group Handout

Proposed vision for the community response to community trauma
FOCUS Pittsburgh Consultative workshop follow-up
June 12, 2014

- **Bio-ecological care plan** (Holistic approach to well-being)
  - **Well-being** - Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO).
  - Street-wide interventions (i.e., Housing co-ops, criteria, education/training)
  - Creation of Peer Support Specialist (Focus Free Clinic)
  - Creation “safe place(s)” to share story or seek help (e.g., FOCUS)
  - Address the spiritual dimension of the individual and community
    - How to address “mistrust” of local churches?
    - Sharing of common faith/morals/spirituality can create and sustain strong communities.
    - Education about benefits/healing associated with having a faith/spiritual dimension (e.g., prayer/meditation, religious practices, mindfulness training)

- Creation of support system for professional and paraprofessional care workers

- Education and training programs for the community
  - Creation or adaption of existing training programs for youth leaders
  - Information about the ACE Study and common trauma responses (how do we disseminate information?)
  - Education about Historical trauma/Transgenerational trauma/Post Traumatic Slave Syndrome (see definition below).
  - Community specific training for community agencies or churches about mental health issues (de-stigmatize mental health) and access to care.
  - Prayer/meditation and mindfulness technique workshops or weekly groups
  - Community specific primary and behavior health interventions
    - Trauma informed care
    - Existential approach to trauma healing
    - Support groups & psycho-educational groups
    - Collaborate with YMCA
Questions for group:
  o Initial feedback about proposed vision?
  o Is there information missing?
  o What assets, organizations, or strengths already exist in the Hill? Who needs to be included in the conversation that is not here? Who are the allies in the community? Who needs to be persuaded?
  o Prioritize intervention strategies “how does the community begin to heal?”
    ▪ What needs to be developed or created?
    ▪ Which “root causes” of community trauma do we address first?
    ▪ Agree on 5 goals
    ▪ Who will do the work?

From consultative workshop:

Barriers to Treatment
  - No “safe place to tell story”
  - Distrust/mistrust of healthcare system, churches, peers, family, friends, law enforcement
  - Racism/discrimination (interpersonal, institutional, and cultural)
  - Stigma (tied into the idea of “no safe place to tell story”)
    ▪ Family-“what happens in the family stays in the family”
    ▪ Community disproval
    ▪ Church/faith communities
  - Poverty (“it is hard to just live”)
  - Transportation
  - Navigating healthcare system

Responses from workshop are similar to current research findings

Individual/interpersonal barriers
  - Experience of daily crisis or stressful lives
    - Insufficient finances
    - Transportation
    - Lack of time or competing obligations or “too much hassle”
    - Difficulty obtaining services

Institutional barriers:
  - Unfamiliar with clinical services or intimidated by institutional processes
  - Lack of trauma informed care services

Cultural barriers:
  - Family disproval (stigma)
  - Community disproval (stigma)
  - Church/faith community (Faith alone will heal you or take away ones problems)
Post Traumatic Slave Syndrome (PTSS)
Post Traumatic Slave Syndrome is a condition that exists when a population has experienced multigenerational trauma resulting from centuries of slavery and continues to experience oppression and institutionalized racism today. Added to this condition is a belief (real or imagined) that the benefits of the society in which they live are not accessible to them.

Multigenerational trauma together with continued oppression and Absence of opportunity to access the benefits available in the society leads to…

Post Traumatic Slave Syndrome. \( M + A = P \)

Three categories associated with common patterns of behaviors as a result of historical trauma; (a) Vacant Esteem, (b) Ever present anger, and (c) Racist socialization

Working definition of community trauma in the Hill
“A shared experience of suffering that characterizes the personal experiences of many in the community. Chronic unemployment, crime, drugs, homelessness, hunger, abuse, poverty, and most profoundly brokenness and radical isolation have all created a culture informed first and foremost by trauma. For this reason, trauma is the foundation upon which the community worldview is laid” (P. Abernathy).
Appendix J: Second Follow-Up Focus Group, Trauma-Informed Community

**Trauma Informed Development Strategy**

1. **Street Interventions/Bio-Ecological Care Plan**
   a. Food Insecurity
   b. Health
   c. Unemployment
   d. Financial Literacy
   e. Income
   f. Debt
   g. Education
   h. Energy Assessments
   i. Green Technology
   j. Credit Score
   k. Housing Retention
   l. Housing Condition
   m. Vacant Lots
   n. Street Conditions
   o. Police Liaison

2. **Behavioral Health Community Organizers**
   a. Training
   b. Recognize Behavioral Health Issues
   c. DE stigmatize Mental Health Treatment

3. **Housing Co-op**
   a. Rules
   b. Limited Equity

**Components of the Integrative Approach to Trauma Informed Development Strategy**

1. **Increased Access to Health Care**
   a. VIM
   b. FQHC
   c. Insurance

2. **Workplace Mental Health Program**

3. **School Support**
   a. Monday Morning Interventions

4. **Primary and Secondary Industry Development**
   a. Bringing dollars to the community instead of taking money from the community.
   b. Emerging Markets
   c. Mental Health Support
      i. Employee Assistance Program
   d. Workforce Development
      i. Professional Development Academy
Appendix K: Code Book

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### Appendix L: List of Codes and Associated Groups

#### Codes: List of Codes and Associated Groups

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Appendix M: Atlas.ti Conceptual Map
Appendix N: IRB Consent to Participate Form

DUQUESNE UNIVERSITY
600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Designing Accessible Mental Health Care in an Urban Community: Lived Experiences of Key Stakeholders Planning Emergent Community-Based Services

INVESTIGATOR: Matthew Walsh (PhD Candidate)
(412) 396-5045

ADVISOR: Dr. Lisa Lopez Levers, Ph. D.
School of Education
412-396-1871

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in Counselor Education and Supervision at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate how community trauma may affect social as well as individual recovery and the process of healing in the community context. You have been identified as a key stakeholder in the community because of your professional or paraprofessional work in a community affected by community trauma. Participants are asked to participate in a one-day consultative workshop. The workshop will last approximately six hours and will include lunch and other breaks. During the morning session, experts in areas related to community trauma will provide
information concerning specific relevant topics. Participants will break into focus groups after the morning and afternoon sessions to problematize and offer potential solutions for emergent community-based services; key points made during the groups will be captured on newsprint by a reporter who is designated by the group. The sessions of the consultative workshop will be videotaped for transcription and analysis purposes. All materials used during the workshop as well as newsprint used for the focus groups will be collected by researcher and used for the analysis. You may be asked to allow me to interview you, and these interviews will be audio taped and transcribed. In addition, you may be asked to facilitate some of the small-group discussions. These are the only requests that will be made of you.

RISKS AND BENEFITS: There are no risks greater than those encountered in everyday life. While there are no direct benefits to you, the information collected in the study can be of benefit in understanding best-practice ways of designing community-trauma-abatement programs.

COMPENSATION: There will be no compensation for participation in this study. However, participation in the project will require no monetary cost to you.

CONFIDENTIALITY: Your personal identity will never be revealed to anyone who reads the research. Confidentiality cannot be guaranteed regarding the information that you share in the focus groups, although the request will be made that everyone involved in the focus groups respect common norms related to keeping group information confidential. The information that you may provide to the researcher in an individual interview will be kept confidential and not reported in connection to your identity in any way. Each participant will be given a unique pseudonym in the final written analysis. All raw audio/video materials will be destroyed after transcription. All written data, including consent forms will be kept in a locked file cabinet in my home and password secured on my computer for at least five-years after completion of the research.
RIGHT TO WITHDRAW: You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Mr. Matthew Walsh at 412-396-5045, Dr. Lisa Lopez Levers at 412-396-1871, and Dr. Linda Goodfellow, Chair of the Duquesne University Institutional Review Board 412-396-6326.

____________________________________  _________________
Participant's Signature                  Date

____________________________________  _________________
Researcher's Signature                   Date