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Beneath the Bandage: The Impact of Violence on Individuals and Communities

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Beneath the Bandage: The Impact of Violence
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Chapter 1

Violence in Rochester, NY

Introduction

Violence is an issue nationally and locally within the City of Rochester. It is one of the most complex issues that society faces and attempts to resolve. However, despite many efforts to combat violence, it persists. Research shows that since the early 2000's, there have been fluctuations in the number of homicides and shootings in Rochester, but long-term analyses on the level of violence show that it has remained relatively stable over time (Altheimer et al., 2017). Although stable, there is a concentration of violence and many individuals, communities, and institutions are affected by it. This paper will discuss violence in Rochester, NY, specifically through a fatal and non-fatal shooting victim analysis from 2000-2020. Data were collected from the Rochester Police Department's Open Data Portal and analyzed using Microsoft Excel. There is also a heat map of shooting victims in Rochester which was created using ArcGIS Online Mapping software. The goal of this paper is to understand where this problem occurs in Rochester, who is most likely to be victim to violence, and what the nature of violence is in this community.

Although this analysis is specific to Rochester, there are urban communities which are similar to Rochester across the United States which may be experiencing a similar violence problem. Rochester is the third largest city in New York with a population of 205,077 people. According to the United States Census Bureau, 40% of the population in Rochester is Black, 37% is White, and 19% is Latino as of 2019. Nearly one third of Rochester is living in poverty. The median household income was $35,590 in 2019[1]. These data provide a context to the type of city that Rochester is and may inform part of the data presented below.

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[1] Data retrieved from US Census Bureau Quick Facts for Rochester, NY.

Violence in Rochester

One of the first steps to addressing the issue of violence is understanding the nature of it within the community. Fatal and non-fatal shooting are only one type of violence experienced by communities. Others which occur much more frequently include assaults and stabbings. However, those are not easily tracked by the Rochester Police Department. Therefore, only shootings are included in this discussion. Importantly, this indicates that communities are experiencing a higher concentration of violence if all types were to be included. The following data present victim-level analyses of the Rochester Police Department's Open Data Portal.

Figure 1 below shows fatal and non-fatal shooting victims across Rochester since 2000. Yellow indicates a higher concentration of violence victims, red is a moderate concentration, and blue is a low concentration. Shootings appear to be concentrated in certain areas around the center of the city. There is a hot spot indicated by the yellow portion of the map in the northeast area of the city as well as in the southwest area of the city. Although only two major hot spots appear on the map, the red areas indicate where there has still been a large volume of shooting incidents over 21 years. These shootings tend to be occurring in the northern and western areas around the city indicating that they are indeed concentrated and are not as likely to occur in the southern areas, specifically, in the southeast areas of the city. These incidents not only affect those living directly in those areas, but it also affects those in the surrounding community as well. Table 1 assists in understanding the concentration of shootings in Rochester.

Figure 1: Fatal and Non-Fatal Shooting Victims 2000-2020

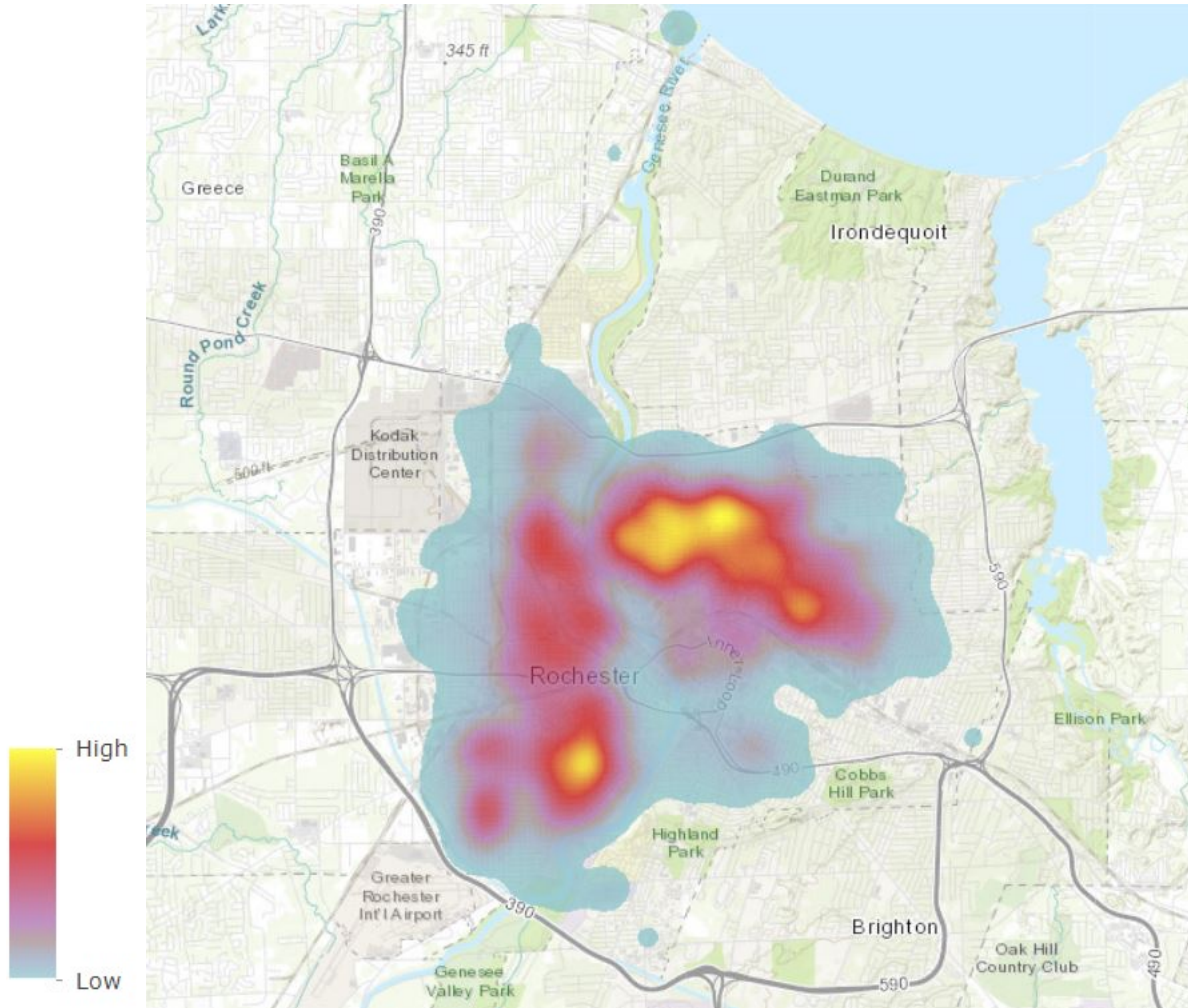**Fatal and Non-Fatal Shooting Victims 2000-2020 (n=4,121)**

Table 1: Fatal and Non-Fatal Shooting Victims 2000-2020 by Zip Code of Shooting

Shooting Victims 2000-2020 by Zip Code of Shooting (n=4,121)		
Zip Code	Number of Victims	Percent
14621	1092	26.5%
14605	562	13.6%
14611	558	13.5%
14608	465	11.3%
14609	404	9.8%
14613	310	7.5%
14606	275	6.7%
14619	235	5.7%
14607	65	1.6%
14615	58	1.4%
14604	46	1.1%
14620	29	0.7%
14612	7	0.2%
14610	4	0.1%
14642	4	0.1%
14614	3	0.1%
14617	2	0.0%
14618	1	0.0%
14624	1	0.0%

Table 1 displays fatal and non-fatal shooting victims by the zip code in which the shooting took place in. The table lists zip codes by largest to smallest proportion of the shootings that took place there over 21 years. This table mirrors the map in figure 1 as the areas with the yellow and red concentrations align to the zip codes with the largest number of victims, as to be expected. The zip code with the largest percentage of shooting victims is 14621 where 27% of the victims were shot in. The overwhelming majority of victims, 75%, were shot within five of the nineteen city zip codes: 14621, 14605, 14611, 14608, and 14609.

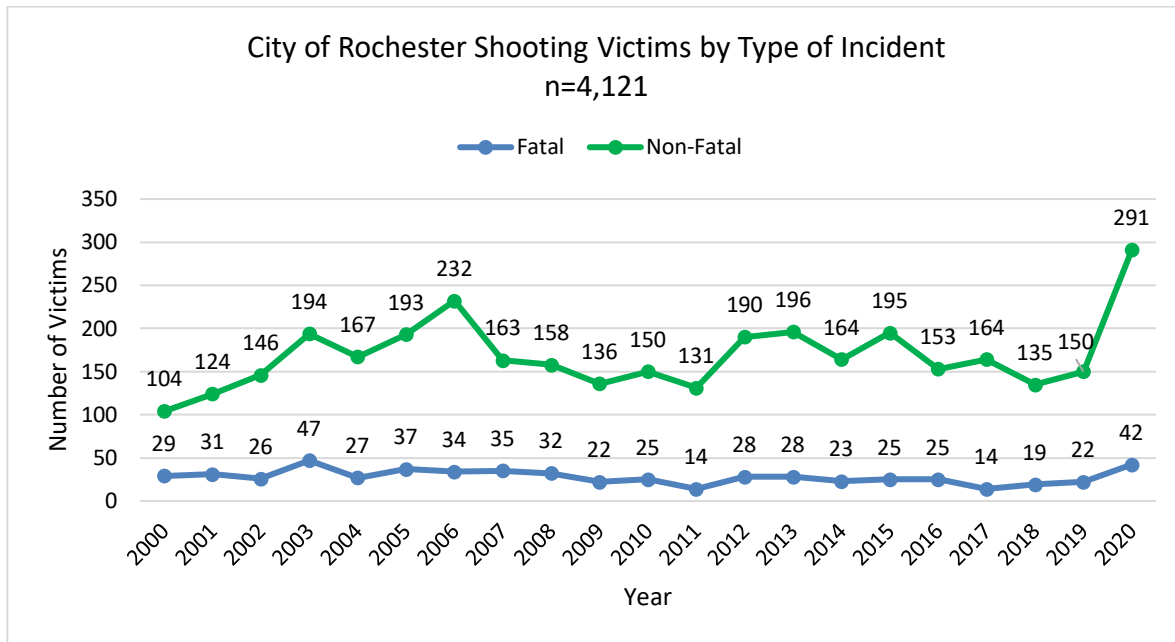Figure 2: City of Rochester Shooting Victims by Type 2000-2020

Figure 2 shows shootings in Rochester, NY, since 2000. Understanding violence over time is important because there are yearly fluctuations in the violence that is experienced. Over the last 21 years there have been on average 28 fatal shooting victims (i.e., homicides) and 168 nonfatal shooting victims. There are on average 196 shooting victims per year (both fatal and nonfatal) and 178 shooting incidents. Since 2000, there have been 4,121 shooting victims and 3,744 shooting incidents. It is important to note that incidents can have more than one victim. Shootings over the last 21 years have remained relatively stable with occasional fluctuations in Rochester, despite a national decrease. However, in the most recent year, cities across the country experienced a dramatic increase in violence including Rochester.

The year with the lowest number of non-fatal shooting victims was 2000 with 104 victims. In 2011 and 2017, there were only 14 victims of fatal shootings. Although 2020 had the highest number of non-fatal shooting victims, 291, fatal shootings were not the highest they have ever been. The year with the highest fatal shooting victims was 2003 with 47. From 2015 to 2018, there was a general reduction in the violence, with over 100 shooting incidents each year (RPD Open

Data Portal, 2020). In 2020, however, communities across the nation and in Rochester experienced

an uptick in the violence with 267 shooting incidents and 333 shooting victims (RPD Open Data

Portal, 2020). It is still unclear what directly caused this spike in violence; however, a variety of

factors could have played a role. These include the COVID-19 pandemic which may have led to

increased frustration, fear, and negative emotions. This pandemic also limited and paused many

violence reduction efforts beginning in March which may have helped to reduce some of the

incidents had they not been interrupted (Altheimer et al., 2020). In 2020, bail reform also began

which essentially released individuals pre-trial. However, there is currently no data on this reform

to indicate that it could have led to an increase in violence. Therefore, there is no clear indication

as to why there was a nationally increase, but it could have been due to a variety of cooccurring

factors, a few mentioned above.

Figure 3: City of Rochester Shooting Victims by Month of Occurrence 2000-2020

Figure 3 displays the combined monthly total for Rochester shooting victims from 2000-2020. The number of fatal and non-fatal shooting victims peak from June to August and then decrease as the months get colder. February has had the least cumulative number of shooting victims (n=191) with July having the most (n=488). Despite there being a concentration of violence in the warmer months of the summer, violence is occurring all year round. Across 21 years, there was not one month where no shootings had occurred. In February 2011, there were only 3 victims which is the fewest there ever was. The highest number of victims to ever be in a single month occurred in July 2020 with 48 shooting victims. On average from 2000-2020, there have been 16 shooting victims per month with February having the lowest average (9) and July having the highest (23). This is consistent with the findings in figure 3.

Figure 4: City of Rochester Shooting Victims by Day of Occurrence 2000-2020

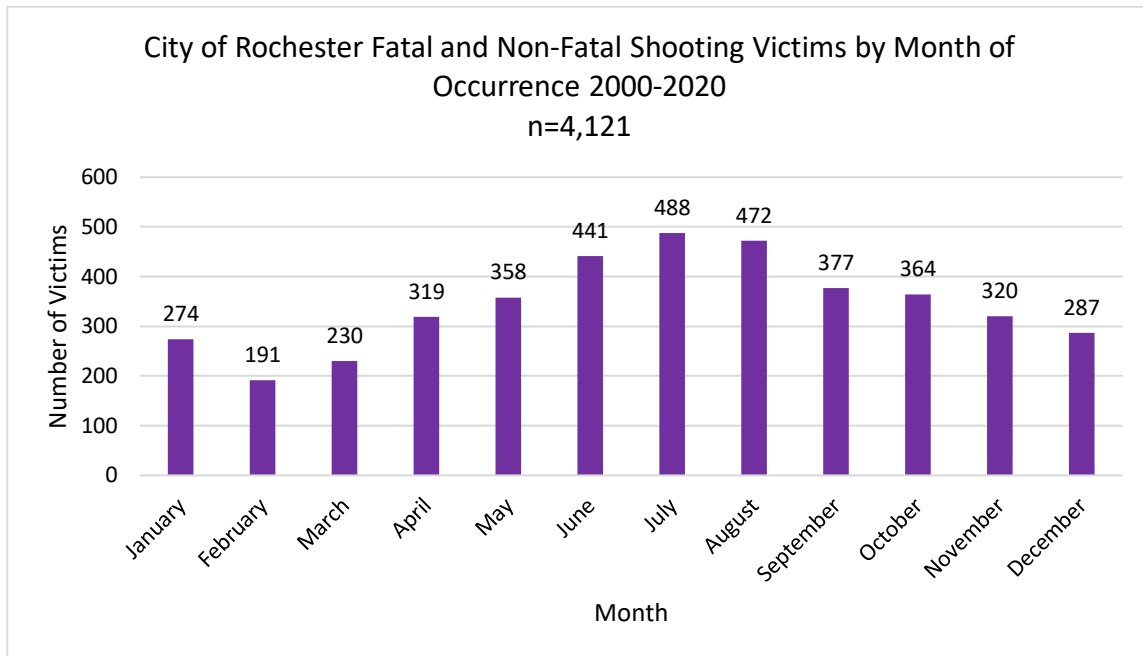City of Rochester Fatal and Non-Fatal Shooting Victims by Day of Occurrence 2000-2020 n=4,121
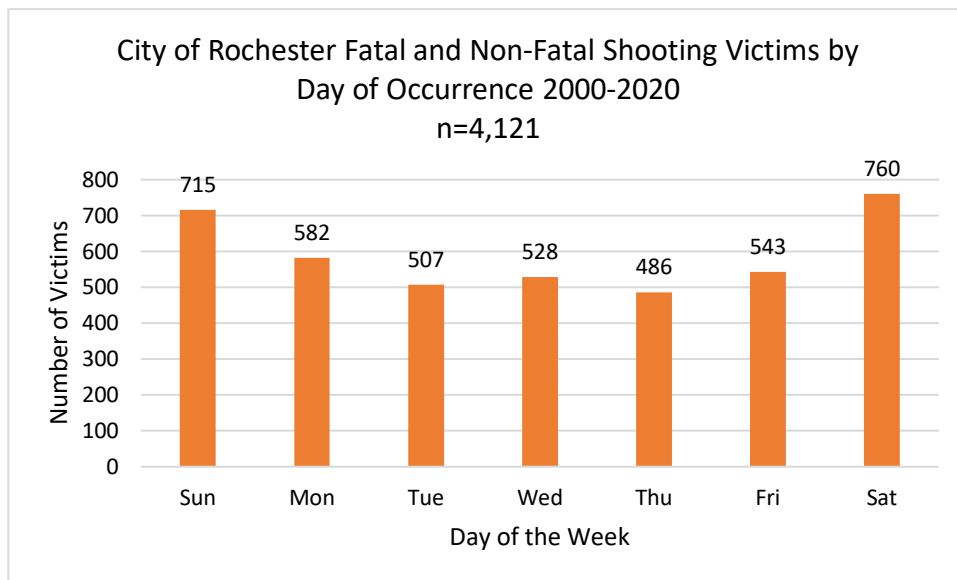
Figure 4 displays the combined daily total for Rochester shooting victims from 2000-2020. The number of fatal and non-fatal shooting victims is highest on the weekends, Friday through Sunday and lowest during the middle of the week Tuesday through Thursday. Violence is

occurring throughout the week on all days. Thursday has the lowest cumulative total with 486 shooting victims across 21 years while Saturday has the highest 760. Nearly 50% of the shooting victims were injured on Friday, Saturday, or Sunday. The remaining 50% were injured Monday through Thursday. This indicates that efforts to target this issue should be prepared throughout the year, all months, and days of the week.

Figures 5 through 7 below display fatal and non-fatal shooting victims by demographic variables. Demographic variables are also important to this discussion as understanding who are most impacted by the violence can help to explain why it persists and how it can be prevented. Although data are combined to include fatal and non-fatal shooting victims, the findings remain the same for both types of shootings individually.

Figure 5: City of Rochester Shooting Victims by Gender 2000-2020

City of Rochester Fatal and Non-Fatal Shooting Victims by Gender 2000-2020
n=4,121

Female 11%

Male 89%
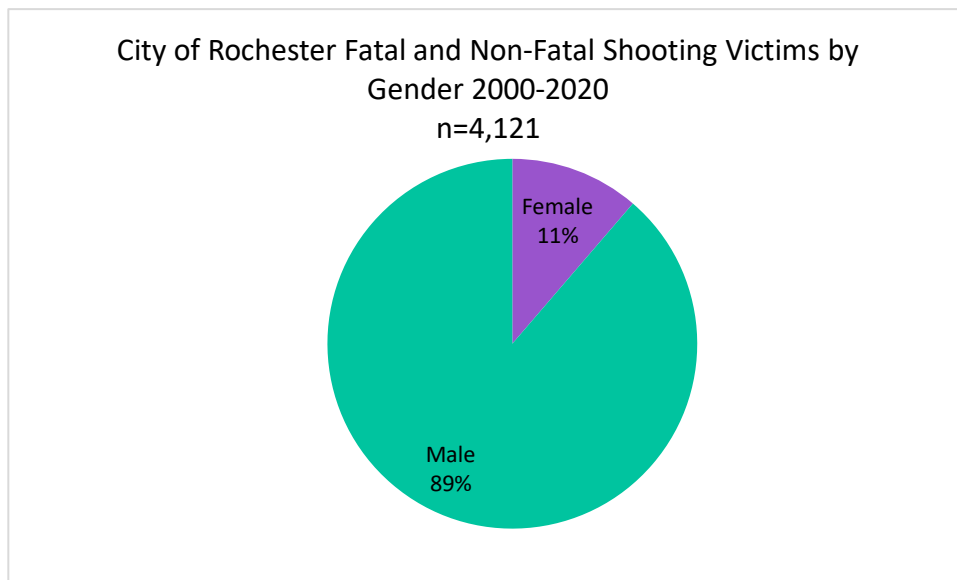
Figure 5 above displays fatal and non-fatal shooting victims by gender. The overwhelming majority of shooting victims are male (n=3,655). However, nearly 52% of the individuals living in Rochester are female (US Census Bureau, n.d.). This indicates that males are disproportionately

victims of shootings in Rochester.

Figure 6: City of Rochester Shooting Victims by Race and Ethnicity 2000-2020
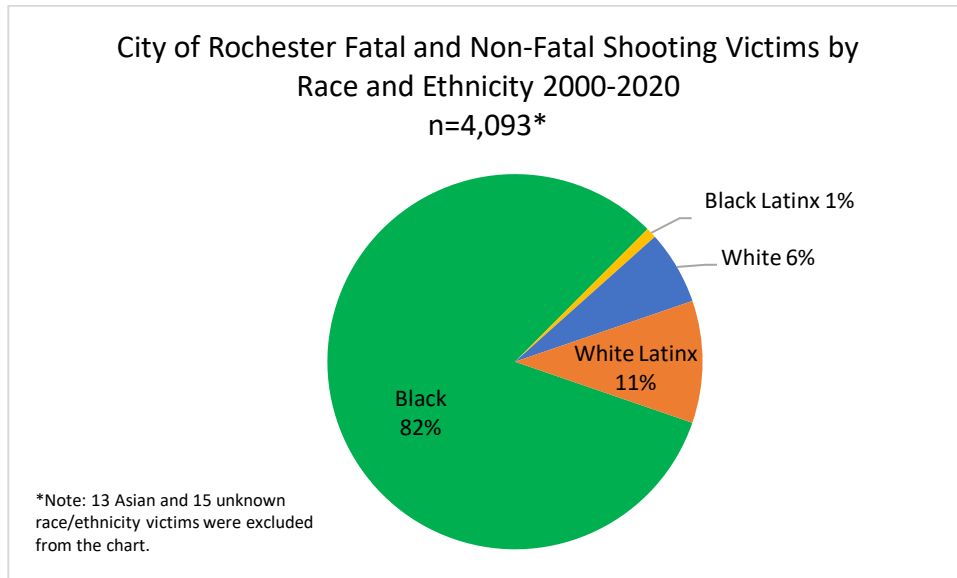
Figure 6 displays the race and ethnicity of shooting victims since 2000. There were 28 victims who were removed from this chart due to an unknown race/ethnicity. Black victims make up the overwhelming majority of shooting victims, 82%, (n=3,365) despite making up 40% of the population in Rochester (US Census Bureau, n.d.). About 37% of the population in Rochester is White (US Census Bureau, n.d.). However, white non-Latinx are only 6% of victims of shootings. The smallest proportion of victims are Black Latinx.

These findings are consistent with the research around race and violence. Blacks are disproportionately affected by violence. According to the Bureau of Justice Statistics, National Crime Victimization Survey, from 2005-2019, although the violent crime victimization rate has decreased by 26%, homicide remains the leading cause of death for black males ages 15-34 (Centers for Disease Control and Prevention [CDC], 2018). Findings from the literature also indicate that there is a disproportionate number of minorities, African Americans, and men who

are involved in violent crime (Outland, 2019; Sampson & Wilson, 1995). African American youth are arrested for forty-two percent of the violent crimes committed, yet they only makeup 16% of the youth population (Outland, 2019). African Americans made up 54% of the homicide victims in 2019 despite making up only 13.4% of the total United States population (US Census Bureau, n.d.). These findings show the disproportionate effect violence has on black males which is consistent to the findings in Rochester.

Figure 7: City of Rochester Shooting Victims by Age 2000-2020
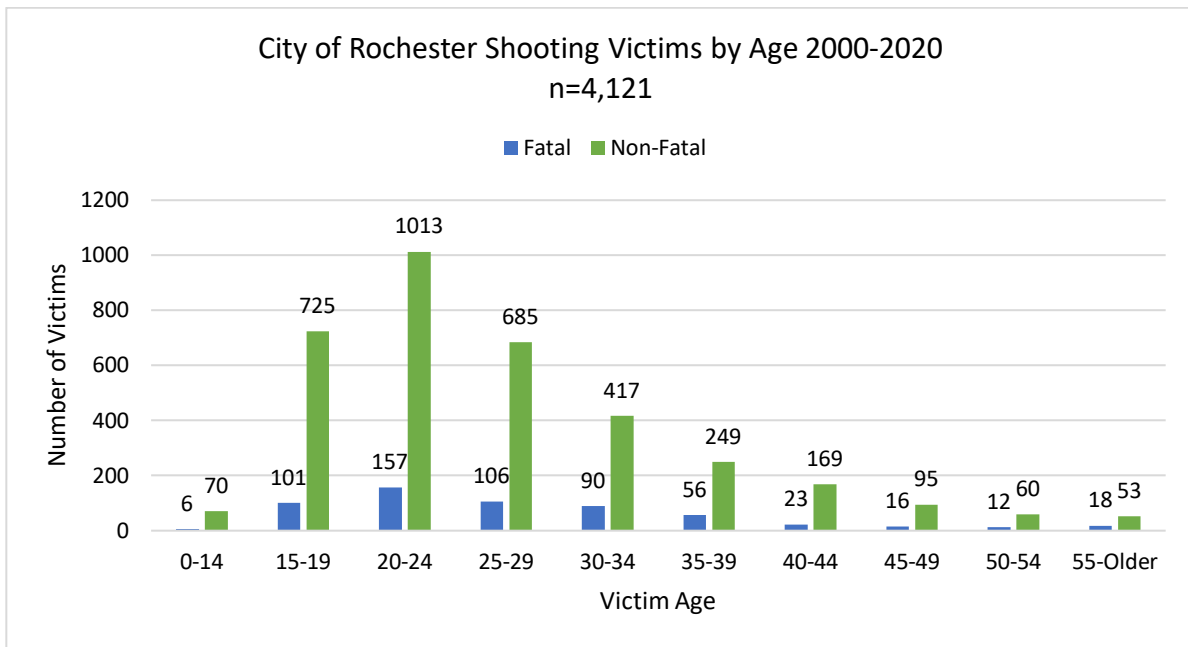
Figure 7 displays shooting victims by victim age. For ease of analysis, ages have been grouped. The youngest victim of a shooting from 2000-2020 was 0 years old and the oldest was 81 years old. The majority of shooting victims are between the ages of 15 and 34 for both non-fatal and fatal shootings. The largest proportion of victims are between the ages of 20-24 where there is a peak in the number of shooting victims. As age increases, the number of shooting victims decreases. The median age of a shooting victim from 2000-2020 was 24 years old indicating that

half of victims are older, and half are younger than 24. Although much of the existing research focuses on youth, all ages are affected by violence with the highest concentration extending beyond the typical parameter of youth which some include as 24 and younger. There are still a large portion of victims who are 25-34 and older who are not included as often. Many of the efforts to reduce violence in Rochester and cities across the nation focus on youth and children. However, this data show that all groups should likely be considered.

Figure 8: 2015 Homicide Victimization Rates for Specific Groups in 2015
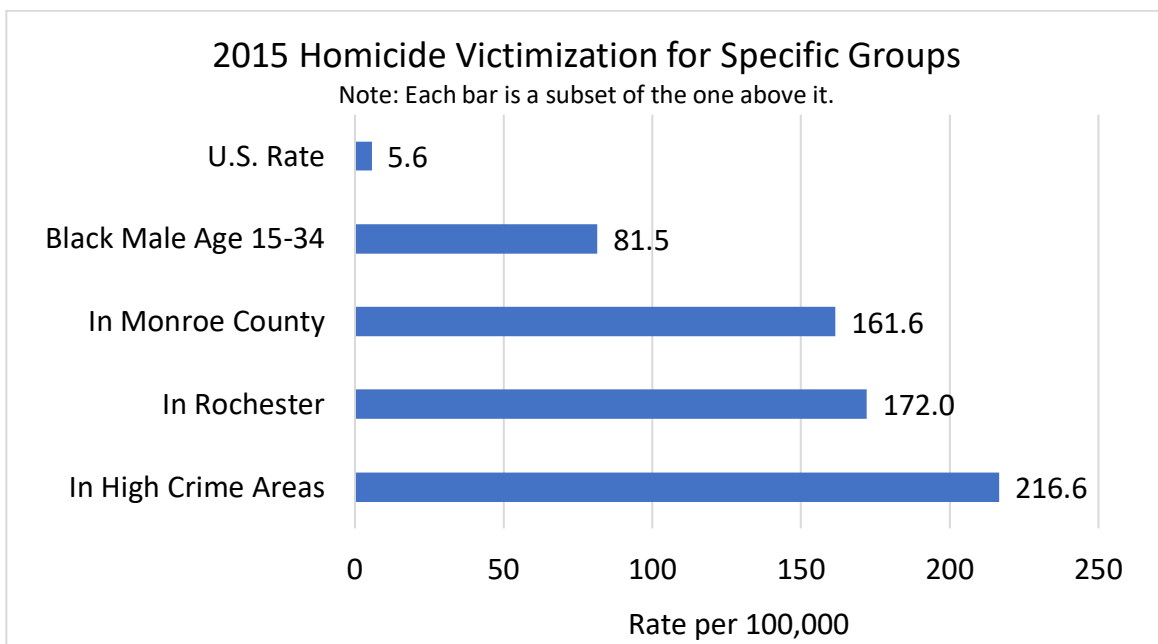
Figure 8 displays homicides rates for specific groups in 2015 per 100,000. The data presented in the chart above was collected and calculated based on United States Census Bureau, The Center for Disease Control (CDC), and the Rochester Police Department's Open Data Portal. "High crime areas" includes the top five zip codes that encompassed the majority of shooting victims in table 1: 14605, 14608, 14609, 14611, 14621. Each bar is a subset of the one above it. For example, the second bar displays the 2015 homicide rate for black males ages 15-34 in the United States which is 81.5 per 100,000 which is fourteen times higher than the national homicide

rate[2]. This rate nearly doubles for the same demographics in Monroe County and then is even higher for young black men in Rochester.

Based on population demographics of the City of Rochester and homicide rates, young black males living in those high crime concentrated areas have a 2015 homicide victimization rate of 216.6 per 100,000. This is thirty-nine times higher than the national 2015 homicide rate of 5.6 per 100,000. Therefore, an individual who is young, black, and male living in the zip code 14621 is 39 times more likely to be a victim of homicide than a young, black, male living anywhere else in the United States. In 2015, the homicide rate for young (ages 15-34) Latino males was 17.7 per 100,000 which is three times higher than the national homicide rate[1]. In contrast, the 2015 homicide rate for young (ages 15-34) white males was 7.1 per 100,000 which is only 1.3 times higher than the national homicide rate[1].

In Rochester, homicides are not the majority of violence occurring in the city. Non-fatal incidents such as aggravated assaults and shootings are much more likely to occur. This indicates that if the rate for this population for non-fatal incidents was calculated, it would be much higher than the fatal incident rate. This allows us to conclude that young, black, and Latino males who are 15-34 years old are at an even greater risk to be a victim of non-fatal violent incidents and likely make up the overwhelming majority of victims included in this analysis. This statistic indicates the importance of evaluating non-fatal violent incidents. These findings are consistent with national statistics on violence and violence victimization.

Research on fatal and non-fatal shooting incidents in Rochester also reveal that not all incidents result in an arrest of a suspect. From 2011 to 2017, 21% of non-fatal shootings were cleared by an arrest as compared to about half of the fatal shootings in the same time period

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[2] Data retrieved from US Census Bureau and the CDC.

(Altheimer et al., 2018). This also shows the disparate effort and priority that is placed based on seriousness of the offense. More attention and resources may be focused on fatal victims who died as a result of their injury as compared to those who survived. Therefore, 69% of these non-fatal instances an individual is not arrested for the crime and is still living life as usual in their community. This could assist in the understanding, in part, the retaliatory nature of violence within Rochester's communities which will be discussed below.

Nature of Violence in Rochester

Prior research in the City of Rochester has been conducted to understand the nature of the violence that occurs. The nature of violence in Rochester is consistent with the literature around violence with large concentrations in certain areas of the city, disproportionately affecting young, black, males and is often fueled through retaliation. Research has found that 60% of the shootings in Rochester are dispute related (Altheimer et al., 2019). Dispute related violence is when two or more individuals engage in two or more acts of violence and there is risk for further violence to occur. Disputes can fuel violence in communities due to the bases of retaliation. Research has found that annually more than 75% of the homicides that occurred were the result of retaliatory violence (Klofas, 2001). For example, these situations are where non-fatal instances of violence (e.g., assaults, stabbings, shootings) lead to revictimization of another individual and this incident results in a fatal incident. For example, it could be that a victim was stabbed and out of anger for this victimization, they retaliate against another and fatally shoot an individual. The percentage of non-fatal shootings resulting in an arrest is lower than those which are fatal. This may indicate that these disputes also do not finish until an individual has been fatally injured. Even then, they can continue depending on the intensity, number of members and type of dispute that is present.

Consistent with an understanding of escalation of violence, disputes can escalate from

assault to stabbings or shootings. This research only analyzed shooting incidents, but it could be proposed that an even higher percentage of violence is related to disputes. Disputes in Rochester have been found to center around money, property, drugs, romantic relationships, and domestic or intimate partner issues (Altheimer et al., 2013). An analysis of shootings in Rochester found that more than 40% of the disputes that occurred from 2010 to June 2013 occurred because of money, property, or drugs (Altheimer et al., 2013). Nearly half of the incidents were also related to gangs (Altheimer et al., 2013).

Dispute violence can be tracked over time. Disputes do not escalate immediately; retaliation occurs over time. For example, in 2010, 20% of the homicides that occurred were the result of an escalation of a dispute that occurred at least 2 hours prior to the homicide incident (Klofas et al., 2020). From 2010-2012, the average length of a dispute was 33 days (Klofas et al., 2020). However, disputes can last for months and can reactive after time has passed (Klofas et al., 2020). An analysis of homicides in Rochester revealed that 42% of disputes were long term (more than 10 days), 24% were short term (1-10 days), and 12% occurred instantaneously (Klofas, 2001). This indicates that disputes took a while to escalate to a fatal incident. This adds to the complexity of the violence problem in Rochester where it is hard to predict when retaliation for a violent event may occur.

Conclusion

In summary, an analysis of the Rochester Police Department's Open Data Portal, indicates that those most at risk of being victims of fatal and non-fatal shootings in Rochester are black and Latino males who are 15-34 years old. Although victims of all races, genders, and ages can be affected there are groups who are disproportionately more likely to be involved. Violence is concentrated in certain neighborhoods of Rochester with hot spots in the North East and South

West quadrants of the city. It is clear from the data above that violence is a serious issue in Rochester impacting the lives of many individuals and communities. Research on clearance also indicates that traditional responses to violence that include law enforcement are not reducing the violence that persists within these communities. This may be due to the complex nature of the violence, especially those centered around a dispute. Even when disputes are analyzed, there is a portion where the underlying cause or reason for the dispute is unknown. Despite a national decrease in violence, violence in Rochester has remained relatively stable and in 2020 has even spiked.

Rochester has many programs that attempt to combat violence in Rochester. These are a mix of law enforcement led programs such as the Gun Involved Violence Elimination Initiative (GIVE) and community-based programs such as Pathways to Peace, Action for a Better Community's Save Our Youth Program, and many others. However, many of these programs do not consider the potential short and long-term trauma that results from engagement in and exposure to violence. They also fail to include victims outside of youth aged populations. It is unclear how violence in urban communities like Rochester contribute to a collective traumatic impact on the members of these communities. Future papers will work to provide an explanation for the problem of violence in Rochester including, why it may be concentrated in certain communities, what contributes to violence, how it can continue to persist despite efforts to reduce it, and the existing research around dispute related violence.

Chapter 2

Urban Interpersonal Violence: A Theoretical Discussion

Introduction

Violence is very prevalent in society today, and although declining, it still is impacting many communities and lives daily. Rochester, NY, displays this phenomenon with the issue around shootings and violence in various neighborhoods. Violence is a complex issue. Many have not yet clearly defined and agreed upon the definition (World Health Organization [WHO], 2002). The focus of this paper is interpersonal violence. The World Health Organization has defined interpersonal violence as having two pillars: family or intimate partner violence and community violence. This paper will directly focus on community violence defined as "violence between individuals who are unrelated, and who may or may not know each other, generally taking place outside the home" (WHO, 2002). Urban interpersonal violence will be defined as concentrated physical acts occurring between people or groups of people in inner-city communities that are intended to cause harm or injury (Pavoni & Tulumello, 2020).

Much of the work around violence centers on gun violence and homicides. However, there is a larger prevalence of assaults and non-fatal incidents as well. In Rochester, there were on average 28 fatal shooting victims and 168 nonfatal shooting victims per year since 2000 (RPD Open Data Portal, 2021). These non-fatal incidents especially impact individuals, peers, communities, and society in a multitude of ways and they can often escalate to include serious fatal incidents which can be even more detrimental to communities. This paper works to understand the concentration of violence in urban communities, what contributes to violence, and why violence continues to persist in these areas. The first step to targeting urban interpersonal violence is understanding the nature of its existence including how community level conditions can impact individual level decisions and experiences. This paper will provide a discussion of the current theoretical literature to understand retaliatory violence and the applicability of this theory to explain violence in Rochester.

Literature Review

There are many theories that attempt to explain violence and the existence of violence in communities. There is no one theory that alone explains violence in communities. Some theories argue that community-level dynamics influence violence, while others lean toward individual-level factors. It appears that there are many cooccurring factors that influence urban violence, which often makes targeting this issue difficult. Violence is a complex issue (Kilby, 2013) partly explained by Shaw and McKay's social disorganization theory, Agnew's strain theory, and Anderson's code of the street. These theories are important to understanding urban interpersonal violence because violence is concentrated in certain neighborhoods with existing and persistent levels of strain placed on individuals within these communities; this strain can motivate some individuals to be involved in violence. Further, Anderson's code of the street assists with understanding the individual level participation in the violence in these communities and the resulting retaliatory nature of the violence that occurs.

Violence disproportionately affects certain neighborhoods and residents within them. In their spatial analyses of crime and violence, Shaw and McKay (1942) found that crime was concentrated in certain neighborhoods regardless of the population of individuals who resided there. These neighborhoods were thus characterized as disorganized. This disorganization is the result of three neighborhood components; poverty, residential instability, and ethnic heterogeneity, which not only indicate disorganization within a neighborhood but in turn, affect crime rates by reducing the capacity to deter crime through social control mechanisms (Shaw & McKay, 1942). Shaw and McKay argued that a breakdown in informal social control and the cultural exposure to criminal behavior leads to higher rates of crime (e.g., violence engagement) in these neighborhoods (Shaw & McKay, 1942). Socioeconomic status can affect crime rates as those neighborhoods lower in status often have less resources or money allocated to them for informal

and formal control that may lead to a reduction in crime (Sampson & Groves, 1989; Shaw & McKay, 1942). Residential instability leads to less social networks and cohesion amongst those living in the neighborhood which in turn decreases the informal capacity to deter crime (Shaw & McKay, 1942). Neighborhoods which are more ethnically diverse may have barriers to communication and consensus in crime reduction (Sampson & Groves, 1989). Sampson and Wilson (1995) proposed that it is the interaction between community level factors, structural disadvantages, the political economy, and larger historical factors that influence communities and lead to disorganization. Disproportionately, violence affects African Americans because the cultural and structural conditions by which black individuals are exposed to and experience lead to increased levels of strain that in turn encourage higher rates of engagement in violence.

Research has also found that neighborhood disorganization is strongly associated with exposure to violence (Butcher et al., 2015). There are cultural and structural conditions experienced by individuals in disadvantaged communities that place them at greater likelihood to engage in violence as a result. These disorganized and disadvantaged neighborhoods are where violence is likely to occur as poverty, residential instability, and ethnic heterogeneity create opportunities for violence. These factors can influence the community's informal mechanisms that may prevent violence from occurring, such as formal and informal group engagement and community participation. Further these neighborhood conditions create community strain which leads to the adoption of street values and fuels retaliation. Disorganization leads to the creation of delinquent groups with their own values and ideals of social control (Shaw & McKay, 1942).

Although Shaw and McKay's theory has received some criticism, there have been studies to validate this theory. Studies find that instability, poverty, and heterogeneity in neighborhoods predicts violence such as homicides (Mares, 2010). Sampson and Groves (1989) extended the work of Shaw and McKay and found that variables indicative of social disorganization in

neighborhoods (such as low organizational participation, unsupervised peer groups, and scant social networks), lead to higher rates of crime. This neighborhood disadvantage influences the nature of violence in communities by decreasing informal social control. Not only are communities experiencing social disorganization, but they are also affected by social isolation which leads to overall concentrated disadvantage (Sampson & Wilson, 1995).

Neighborhood disorganization and concentrated disadvantage create community level strain which can also assist in explaining the variation of violence in communities. Agnew's (1999) macro strain theory argues that poverty, residential mobility, concentration of people or overcrowding, inequality, and the ethnic/racial makeup of the neighborhood (non-white), increases the level of strain in a neighborhood. Neighborhood disadvantage significantly increases the level of strain in a community (Warner & Fowler, 2003) which has been found to have a significant effect on the levels of violence. Social support or neighborhood stability are protective factors for the impact of community strain (Warner & Fowler, 2003). Warner and Fowler (2003) found that strain did not lead to increases in violence in neighborhoods that had high levels of social support, yet it did lead to violence in areas with low levels of social support.

Community strain can impact individuals directly while also indirectly motivating individuals to engage in crime. Agnew's general strain theory states that stressors put on individuals that are strong, perceived as unjust, or associated with low social control increase one's motive to be involved in crime (Agnew, 1992). Strain is the result of three categories; the inability to achieve goals, the removal of something from the individual, or exposure to adverse situations or factors (Agnew, 1992; Lilly et al., 2018). Individuals who live in urban neighborhoods often experience strain such as, high poverty levels, existing trauma from other violence, unemployment, among other factors, which can lead to increased levels of violence. This is because experiencing strain can lead to heightened emotional responses such as stress, frustration, and anger amongst

many in the community (Warner & Fowler, 2003). The heightened emotions experienced by residents can create a space where violence flourishes. Strain theory proposes that strain can lead to anger, which can lead to increases in violence in communities through individual interactions (Agnew, 1992; Agnew, 1999). Social disorganization and strain that is prevalent in these neighborhoods can affect the whole community leading to informal mechanisms of social control. Further, this strain and the informal mechanisms of violence that occur can affect the individuals within them.

The strain and disadvantage of these neighborhoods leads individuals to engage in behaviors to overcome and manage these experiences. Individuals adopt a set of values termed the "code of the streets" by Anderson (1999) that regulate violence in communities due to the lack of economic opportunity, social alienation, and racial discrimination they experience. In his ethnographic study in inner-city Philadelphia, he established that there are a set of informal rules that create a space where violence is justified to maintain one's reputation in the community (Anderson, 1999). Street status and reputation are important to individuals in these urban communities as status amongst other areas such as educational attainment, careers, and family roles are affected by disadvantage (Anderson, 1999). Individuals living in neighborhoods which are disadvantaged and strained are at a greater likelihood to be engaged in violence, but it is ultimately the street culture and specific characteristics such as strain, affecting the individual directly that will push them to be engaged in violence (Dickinson, 2015). For example, interviews with violence victims revealed that situational factors or past violence and the environment were the two reasons that led these individuals to engage in violence (Outland, 2019). Therefore, it was not that they felt that it was their choice to engage in violence but that the situations they were in and the environmental conditions gave them no other option.

The informal rules that regulate violence are adopted by individuals in urban areas as a

form of protection to defend oneself and maintain masculinity. Manhood is seen as a form of

respect, self-reliance, and strength in relation to violence (Kurtenbach & Rauf, 2019). Violence

occurs when manhood is challenged and insulted in the streets. Respect is at the center of street

code regulating engagement with others, and when respect is undermined, "street justice" must

take place (Anderson, 1999; Outland, 2019). Street justice means handling a problem oneself and

often results in violence. When someone is disrespected, the street code says that one must respond

aggressively to gain respect back. Respect is influenced by the type of clothing someone wears

(e.g., brand name), how someone looks at another person (e.g., demeanor) and even physical

disrespect (e.g., violence) (Anderson, 1999). Disrespect, maintaining masculinity or manhood, and

preserving street status are all key components of the street culture (Anderson, 1999; Kubrin &

Weitzer, 2003).

Street justice can also occur when there is a breakdown of legitimacy and trust in

institutions (e.g., law enforcement) to handle the issue of violence (Anderson, 1999). Regardless of

the type of disrespect experienced, the need to take matters into one's own hand stems from a lack

of police accountability. Lack of faith in the police was emphasized by more than half, 65% of the

participants in Rich and Grey's (2005) qualitative study. The belief is that they can handle it

themselves and do not need the police for assistance. These individuals also experience harassment

and racial profiling further creating mistrust in police (Rich & Grey, 2005) which can foster

violence in communities (Anderson, 1999). Individuals in these communities viewed the police as

a last resort option for assistance, did not trust them to protect them or their family, and they would

not cooperate with investigations because they do not believe that the police are interested in them

or finding the perpetrators of violence in these communities (Kubrin & Weitzer, 2003; Rich &

Grey, 2005). Furthermore, due to the code of the street these killings were seen as justified and

deserved, therefore not needing legal justice (Kubrin & Weitzer, 2003). This is what is occurring

in Rochester's neighborhoods as well. The lack of arrests being made in cases of fatal and non-fatal shootings contributes to a decline in police trust and legitimacy. Therefore, individuals within these areas must turn to other means.

Many studies have tested the work of Anderson and the theory holds true. Kubrin and Weitzer (2003) found that in neighborhoods characterized as disadvantaged, there were a larger percentage of retaliatory homicides. Further, they revealed that the retaliatory homicides in these neighborhoods tended to be the result of cultural street code values (Kubrin & Weitzer, 2003). According to participants in these studies, violence was a way to maintain respect and reputation (including family and personal reputation) (Kubrin & Weitzer, 2003; Kurtenbach & Rauf, 2019; Outand, 2019). Maintaining this reputation was a motive for adopting the code of the street and was even a form of protection (Kurtenbach & Rauf, 2019). When this reputation is challenged, violence is utilized to defend it. Those who engage in violent behavior gain more respect, recognition, and are positively viewed by others (Outand, 2019). This reinforces and normalizes the behavior. When someone injures another by being violent, that is also seen as a loss of respect and therefore the way to gain respect again is to be violent in return (Rich & Grey, 2005). Failure to defend oneself after being a victim makes the individual appear weak and puts them at risk for further victimization (Anderson, 1999; Jacobs, 2004; Rich & Grey, 2005). Reflexive retaliation (e.g., immediate and face-to-face) is the most aggressive form with two motives: revenge or self-protection (Jacques & Rennison, 2013). Both are approved reasons behind the continuation of violence in neighborhoods set forth by the street code.

Neighborhood concentrated disadvantage creates spaces where there are no outlets to expose of this strain except for engagement in violence. Outand (2019) delves into the disadvantages and life changing issues experienced by urban African American males which were identified by interviewees as poverty, homelessness, and mass incarceration which then led down

pathways towards violence (Outland, 2019). He also found that there is an institutionalized violence and racism theme in the lives of individuals. Individuals experience physical, psychological, and emotional trauma from the violence they encounter, racism, and experiences of others around them (Outland, 2019). This is where community level strain can be seen to lead to individual level strain which can lead to violence and crime. This trauma including, poverty, economic challenges, and structural violence experienced, led them to join gangs, use weapons, and engage in illegal activity to make money (Outland, 2019). Engagement in gangs stemmed from the longing for love, inclusion, and safety (Outland, 2019). These neighborhoods already experience an abundance of disorganization and strain which violence became a solution for.

Some researchers propose that retaliation is one of the stronger types of social control in disorganized neighborhoods, and encourages crime and violence (Jacobs, 2004). Retaliatory disputes are a central component to violence in communities indicating there is a small group of individuals who engage in most of the violence. Disputes can center around gangs, drugs, and relationships, among other issues (Altheimer et al., 2013). Retaliatory disputes are characterized as two or more individuals engaged in two or more acts where there is potential for further violence to occur (Altheimer et al., 2013; Klofas et al., 2020). The code of the street regulates dispute related violence in urban disadvantaged neighborhoods. Berg et al. (2019) found that those individuals who adopted street code values were less likely to mediate their conflicts and more likely to engage in disputes (Berg et al., 2019). The adoption of these values enabled a mindset toward a cycle of violence. Individuals with more public lifestyles were found to strongly believe in the code and were found to be more violently engaged (McNeeley & Wilcox, 2015). Those who were more private did not have a correlation between street code adoption and violence (McNeeley & Wilcox, 2015). However, in Anderson's (1999) study even those who were not labeled as street families felt they had to adopt the code to survive the conditions they were facing.

The strain placed on individuals leads to engagement in street values and culture which inevitably leads to informal social control mechanisms of violence and street justice, which can place further strain and consequences on individuals in these communities. Violence leads to a sense of vulnerability in the aftermath, the components discussed feed this vulnerability and lead to revictimization and retaliation. Self-protection and substance use were deemed as two ways to overcome this vulnerability (Rich & Grey, 2005). Emotions can also play a role in violence where anger and fear can be the result of neighborhood disadvantage, the strain placed on communities such as fear of the police (Kubrin & Weitzer, 2003), and fear of further victimization due to street culture norms (Anderson, 1999). This emotional reaction can determine one's response to an incident, whether they act in revenge because they are upset or act in self-defense or protection because they are scared.

Retaliation can range from no response at all to harm without injury including verbal responses to lethality with a weapon and even death (Jacques & Rennison, 2013). This variation has been found to be due to the social distance between the victim and offender. In cases where the victim-offender social distance is closer (i.e., know one another and same race), it is less likely that retaliation will involve a more serious weapon such as an object, knife or gun, and more likely that bodily harm will be used (Jacques & Rennison, 2013). In cases where the victim-offender social distance is further (i.e., strangers to one another and different races), it is more likely that retaliation will involve a more serious weapon such as a gun, as compared to a knife or object and bodily harm (Jacques & Rennison, 2013). Social distance, the combination of the relationship between victim and offender and the cultural components of race, was found to be important to determining the lethality of retaliation that will occur. However, they found mixed results when evaluating the relational and cultural aspects with weapon lethality individually (Jacques & Rennison, 2013). When the victim and offender are strangers, the victim is twice as likely to

retaliate with a gun as compared to bodily harm (Jacques & Rennison, 2013). The cultural aspect of race did not have an effect when comparing lethality with a gun and bodily harm, but it did have an effect when comparing retaliation with a knife/object and bodily harm (Jacques & Rennison, 2013). This variation of findings indicates that there is a range of responses from victims, and it is hard to predict how such an act will unfold. However, social distance does seem to indicate a potential for more lethal and dangerous retaliation.

Jacobs (2004) outlines the various types of retaliatory violence, reflexive (occurs immediately with face-to-face contact), reflexively displaced (occurs immediately without face-to-face contact), calculated (face-to-face with desired delay), deferred (face-to-face, undesired delay), sneaky (without face-to face contact, desired delay), and imperfect (without face-to face contact, undesired delay). These various types are important because in situations where the retaliation is not face-to-face, it is unclear to the offender and others that the retaliation took place. Without the knowledge of the retaliation taking place against the individual who completed the original act of violence, the code of the streets is undermined.

The various types of retaliation are important for understanding the nature of and continuation of violence in urban communities. Although reflexively displaced, sneaky, and imperfect retaliation occur, it is better that a direct confrontation occurs to maintain street values (Jacobs, 2004). However, to reduce the impact of potential continued retaliation, individuals may choose these other types that are without face-to-face contact. Imperfect retaliation can fuel the disputes in the community and create new, lasting disputes as they target individuals who were not directly involved in the original act. This can partly explain how third parties are involved in the violence, how disputes can escalate and continue over time, and supports the idea that the adoption of the street code does not reduce victimization and instead increases the risk of victimization (Stewart et al., 2006). Kubrin and Weitzer (2003) found that community and family members often

get involved in retaliation not only tolerating the behaviors, but even supporting them. This involves a third unknown party who may have witnessed an act, a community member who feels that the acts occurring are bothering the whole community, and family members who may be defending their children for example (Kubrin & Weitzer, 2003). This can create a space where violence continues to occur. Further, anger could also lead the victim to retaliate against the wrong person, thereby increasing the cycle of violence in the community.

Drug related violence is one type of violence that has been highlighted in the literature. Drug related violence has its own set of motivations; yet still is regulated by street code values. These motivations include, psychological effects of drug use, financial gain or loss, and systemic issues (e.g., failure to pay someone back within the drug market) (Dickinson, 2015). Outland (2019) discovered that while participating in drug sales for a source of income, violence was also used as a solution among participants when competition would arise. Material goods can be a motivation behind retaliation where an individual who retaliates against an offender will be able to maintain respect, show strength, and potentially obtain goods that were taken from them originally (Anderson, 1999; Dickinson, 2015). There is no singular reason behind violent retaliation and violence is not always the response. Dickinson (2015) discusses how individuals can choose not to respond violently and cause harm in other ways such as gossiping or attacking one's street status. Further, with drug-related violence, individuals can choose to justify their lack of retaliation toward another by focusing on financial gain and time that will be available if they do not take action, reframing their victimization to gain respect, or even showing that the offender is not worthy of the retaliatory victimization (Dickinson, 2015). The integration of a drug market with street culture is one such avenue for explaining how retaliatory violence takes place within communities. In Rochester, 40% of disputes were found to be centered around money, drugs, and/or property (Altheimer et al., 2013).

Violence is complex, and often concentrated in urban disorganized communities that experience concentrated disadvantage and strain. This strain and disadvantage can lead individuals to find other values and outlets within the community. Disorganized neighborhoods remove informal social control leaving individuals within them to adopt their own form of control. The collateral strain and disadvantage lead individuals to adopt street code values in order to survive their neighborhood experiences. These values regulate and justify violent behaviors within these neighborhoods, which creates a space where violence is likely to thrive. Retaliation fuels the cycle of violence and exposure to violence can further create strain in the lives of individuals, their families, and the community. This complexity makes it very difficult to target, reduce, and manage violence within urban areas. The theoretical discussion presented in this paper proposes that it is not an individual predisposition to violence engagement due to underlying individual factors. Instead, there is a collective impact of situational and environmental conditions that lead individuals to take part in and fall victims to violence within their community.

The theory outlined in this paper assists in understanding the violence that is occurring in Rochester. Consistent with Shaw and McKay's social disorganization theory, we find that violence is concentrated within certain communities, and certain zip codes. Likely these communities are experiencing high levels disorganization. One element of this disorganization is high levels of poverty. This is true as half of Rochester has a household income that is less than $35,000. These communities are also strained due to a variety of additional factors including the lack of solvability of crimes with a clearance rate of 21%. This community strain impacts the individuals living within them as well. Anderson's code of the streets provides an explanation for the continuation of violence within Rochester's communities as 60% of the shootings were dispute related. This dispute related violence that was described previously is consistent with the existing research on retaliation. Retaliation can be tracked but it is unpredictable. There are many types of retaliation

that can take place, violence can escalate or deescalate depending on the situation, and third parties can even get involved. Yet, this violence can impede the lives of many individuals, families, and whole communities if not managed effectively.

Conclusion

  Theorists and scholars have sought to understand why violence occurs and what causes violence in urban settings. In sum, there is no easy answer. The research discussed above shows that violence is a complex issue; the overlap between factors such as strain, lack of social control, social disorganization, neighborhood disadvantage, and the adoption of street code values can lead an individual to violence. Violence continues to disproportionately affect young, black males in urban communities. Violence does not solely occur due to one reason, it is the collective impact of neighborhood disadvantage, structural disadvantage, individual desires to achieve and feel safe that influence involvement in violence. Violence impacts perception of neighborhoods, individuals involved in the violence, and whole communities.

  The literature presented is limited by the lack of discussion around the short- and long-term effects of this violence in communities. Specifically, the existing research does not discuss the traumatic impact of violence on communities. It can be concluded that violence is a problem nationally and especially locally in Rochester, NY. The literature assists in understanding why this violence may be taking place. However, it fails to capture the resulting impact of this violence on Rochester, and in those concentrated areas that were highlighted. Without this inclusion of the effects, it is unclear how large of an issue violence is and how it may be affecting other areas of lives as well, in the form of trauma. Future papers will discuss how exposure to and involvement in violence within these communities can leave lasting impacts on individuals, their families, friends, and even whole communities.

Chapter 3

Community Trauma

Introduction

Urban interpersonal violence can have a large and lasting impact on the residents who live in urban neighborhoods. This violence occurs between two or more individuals, often in a public setting and includes shootings, stabbings, and serious assaults. Violence results from neighborhood level conditions such as disorganization and strain that impact individuals within these communities. Failure to manage the violence that exists can result in a variety of undesirable outcomes. Current research on violence fails to consider the traumatic impact that violence can have. Trauma places individuals and those connected to them at higher risk for emotional and psychological issues as a result of exposure to and involvement in violence. As was demonstrated by existing research and through an analysis of Rochester, NY, violence is concentrated within urban communities. This concentration of violence can increase the risk of trauma related outcomes especially that of community trauma. Trauma is an important topic because it goes beyond just informing the effects of violence, but further assists in understanding the culture or cycle of violence that occurs in these communities. This paper will discuss trauma including the various types of trauma, effects of trauma including those that result from violence exposure, and methods to manage community trauma. Violence does not just end with the incident and injury, but it can have lasting effects on those who were victimized as well as family, friends, neighbors, and communities who are connected. This paper will integrate the findings from trauma literature with that surrounding violence to assist in the gaps in violence literature which fails to address community trauma.

Trauma

Trauma is defined by the American Psychological Association as an emotional response to a terrible event. Trauma is important to understanding the existence of violence in communities

and informing how to address it. There are variations in the type and level of trauma. Individual level trauma has been the focus of much of the current research around community violence. Individual level trauma impacts the direct individual who was exposed to the event (e.g., the victim of violence). There is also a well-documented concept of collective trauma which may impact an entire group of people who experience the same event (e.g., a natural disaster or act of terrorism) (Audergon, 2004; Hirschberger, 2018; Kellermann, 2007). Collective trauma can be considered similar to what some have termed community trauma, however community violence is not often included in the discussion. Although the literature focuses on collective trauma as a result of these consequential and serious events (Hirschberger, 2018; Kellermann, 2007), violence in urban communities is far more prevalent.

Another type of trauma is generational or historical trauma, which results from the shared experiences of a group of individuals typically related to an event intended to oppress a specific group (e.g., slavery or the holocaust) (American Psychological Association, n.d.; SAMHSA, 2014). Yet few have defined community trauma as a form of trauma resulting from urban interpersonal or community violence. Urban interpersonal violence has the same impact in communities as historically traumatic events, natural disasters, and other documented traumas. A failure to expand beyond an individual focus can result in a continuation of violence and recurrent mental health concerns for people who live in these communities (Jennings-Bey et al., 2015). The distinction across the types of trauma is important for policy recommendations and interventions aimed at reducing violence or the trauma experienced by exposure to violence in communities.

Community Trauma

Community trauma can be defined as a group of people, usually living in the same area, informally experiencing symptoms of trauma after an intense incident has occurred and affected

the people in a certain community (e.g., retaliatory violence) (SAMHSA, 2014). Trauma is bidirectional in its influence indicating that it affects both the individual and those surrounding the individual at the broader societal and community level (Audergon, 2004; Kellermann, 2007). Vicariously, events can be experienced through others and the implications of these experiences can be the same. When an event occurs, such as a mass shooting, it impacts those who were directly involved as well as those connected to the victims such as their families, friends, or community groups. Victims of interpersonal violence are directly impacted by their victimization and may begin to experience trauma symptoms as a result of that experience. Additionally, those connected to the victim will experience trauma from hearing about or witnessing the event and even experiencing the aftermath of the event (e.g., additional news coverage, funeral, or memorial services) (Audergon, 2004). Jennings-Bey et al. (2015) estimate that up to 200 individuals can be affected by a single homicide.

Community trauma, if not addressed, can play a role in the continuation of violence. Witnessing violence and being a violence victim are positively associated with increased levels of violence commission (Ruchkin et al., 2007). This can occur when neighbors and families of violence victims react to the situation and become upset (Jennings-Bey et al., 2015). Furthermore, community violence is often not a single event, it could be multiple events linked together and therefore the emotions experienced can be more extreme (Jennings-Bey et al., 2015). Retaliation fuels violence in communities and additional victims within similar disputes or even the same community can add to the trauma. Anderson (1999) discusses the aspect of street justice which is where individuals handle a situation on their own without formal social control mechanisms. A victim of violence may not want to call police for help and instead get revenge for the violence himself which can create additional trauma especially when a third party is involved. Retaliation can include friends or family of victims who are engaging in violence as a form of street justice. It

is important to understand what the effects of traumatic events are and how they can be experienced as a result of exposure to violence including witnesses and victims at the individual and broader community level.

Effects of Trauma

The existing literature has highlighted trauma extensively with a focus on individual level trauma and youth primarily. A broader focus on how trauma impacts the larger community and other age groups has not been discussed as frequently. It is important to understand trauma across all ages because as an individual gets older the likelihood of having experienced multiple traumas increases. Experiencing multiple traumas overtime leads to a cumulative effect. The effects of trauma impacting individuals can also impact whole communities in similar ways. Experiencing symptoms as a result of a traumatic event is normal, however for some, they can escalate and intensify. If symptoms are not managed, they can get worse turning into clinical psychological diagnoses or leading to serious health problems. Despite the variation in the effects, symptoms of trauma can still be managed and should be addressed by understanding what they are and how they are experienced.

Most commonly, research literature has focused on exposure to adverse childhood experiences (ACE's). The original ACE's landmark study conducted in 1995-1997 highlighted the link between adverse childhood experiences and trauma (Felitti et al., 1998). Specifically, this study wanted to understand the relationship between traumatic experiences in childhood and the effect they have throughout adulthood. The researchers received completed surveys regarding adverse childhood experiences from more than 9,000 adults who had completed a standardized medical evaluation (Felitti et al., 1998). They found that more than half of the respondents had one or more adverse childhood experiences (i.e., psychological, physical, or sexual abuse, domestic

violence, exposure to substance abuse, metal illness, suicide, or imprisoned residents of the home). This study revealed that adverse or negative experiences in childhood have long-term impact for individuals into adulthood and throughout their lives, including the development of serious physical medical issues and psychiatric illness (Felitti et al., 1998). Respondents who reported 4 or more adverse childhood experience categories were 4 to 12 times more likely to have serious health risks (e.g., alcoholism, drug abuse, depression, or suicide), 2 to 4 times more likely to engage in risky behaviors such as smoking, increased sexual partners, and be less physically active and more obese, as compared to those who had none (Felitti et al., 1998). Felitti et al. (1998) also concluded that the more ACE's an individual had experienced, the increased likelihood for development of disease or illness (e.g., heart, lung, or liver disease, cancer, or skeletal fractures). Since this landmark study, various other studies have confirmed and expanded on these findings indicating that adverse childhood experiences increase the likelihood of harmful behaviors in adulthood including violent victimization (Bellis et al., 2014).

Trauma can be displayed in many forms including internalizing effects, externalizing effects, and posttraumatic stress disorder. This makes trauma a complex issue that can often go unnoticed when individuals exhibit few symptoms (Rosenthal, 2000; SAMHSA, 2014). Cumulative or repeat exposure to traumatic events can often increase the likelihood of noticeable effects (Rosenthal, 2000; SAMHSA, 2014). After a single exposure, it can be difficult to identify the impact that a traumatic event is having on an individual or community. Some programs are available to assist in the direct aftermath of a traumatic event, often short term. However, individuals may not start experiencing symptoms or expressing trauma until they have had time to understand the trauma. Since violence is concentrated in certain areas (Shaw & McKay, 1942), there is a high likelihood that trauma goes unnoticed and then a second incident occurs creating repeat exposure which can intensify the trauma. Internalizing effects of trauma can include

emotional and psychological responses, while the externalizing effects can include behavioral changes and physical symptoms. Post-traumatic stress disorder (PTSD) is a psychological response requiring a clinical diagnosis amongst a variety of criteria. It is possible for individuals to display a few of the criteria such as anxiety or depression, without meeting the diagnosis for PTSD. Therefore, it is important to distinguish between internalizing effects, psychological responses, and PTSD. Despite these differences, these effects can be life altering regardless of a clinical diagnosis.

Research has extensively studied the internalizing effects of trauma. The emotional response to trauma is twofold with some individuals having extreme emotional reactions and others who experience little emotions or even numbness (SAMHSA, 2014). The emotional response is often heightened after the most serious trauma event that one experiences (Ganzel et al., 2007). Individuals may experience emotional symptoms of trauma including sadness or grief, numbness, anger or agitation, fear, nervousness, distress, a decreased ability to control emotions, or lack of feeling positive emotions (American Psychological Association, 2019; Audergon, 2004; Jennings-Bey et al., 2015; National Center for Child Traumatic Stress, n.d.; SAMHSA, 2014). A higher level of stress experienced after a traumatic event leads to internalizing psychopathology (Ruchkin et al., 2007). Additionally, feelings of helplessness regarding others in the community who may be victimized or fear and uncertainty around future violence can be experienced (Jennings-Bey et al., 2015; Opara et al., 2020). It seems to be a perpetual fear that violence will continue to occur within these communities and will affect loved ones close by if it is not managed (Opara et al., 2020). Further, heightened emotional responses can lead to more violence within communities as individuals engage in crime as a coping mechanism (Agnew, 1992).

Behavioral changes can include avoidance, engagement in risky behaviors (e.g., substance use or addiction development) and increased aggressive behavior (National Center for Child Traumatic Stress, n.d.; SAMHSA, 2014). Education can also be impacted for adolescents as a

result of detachment from academics (Patton & Johnson, 2009). This can further lead to disconnectedness from important support systems that may be provided at the school or community level which may be crucial to managing trauma (Patton & Johnson, 2009). Physical effects can include, exhaustion, difficulty sleeping, avoidance of activities, people, and places, problems with relationships, and somatic complaints (American Psychological Association, 2019; SAMHSA, 2014).

It is not uncommon for an individual to have experienced various traumatic events over time (SAMHSA, 2014); however, persisting traumatic events can lead to other serious consequences. These consequences can include serious health conditions in late adulthood, such as heart disease and cancer (D'Andrea et al., 2011; Felitti et al., 1998). Many areas of the body system can be affected by exposure to trauma including gastrointestinal, immune system, cardiovascular health, musculoskeletal, reproduction, neuroendocrine, and the brain (D'Andrea et al., 2011). Symptoms of trauma manifest within each of these systems and the risk of developing illness or disease within them is higher if one was exposed to trauma (D'Andrea et al., 2011; Lynn-Whaley & Sugarmann, 2017). Typically, effects of trauma get better with time (American Psychological Association, 2019), yet research has discovered that it can take time to recover from trauma, often many years, even for those who are deemed mentally healthy (Ganzel et al., 2007).

Individuals can also experience psychological responses including, depression, dissociation, anxiety, and post-traumatic stress disorder (PTSD) (National Center for Child Traumatic Stress, n.d.; Patton & Johnson, 2009). These psychological responses can lead to intrusive thoughts, nightmares, hallucinations, flashbacks, and changes in cognitive memory (American Psychological Association, 2019; Audergon, 2004; SAMHSA, 2014). One of the widely discussed outcomes of trauma exposure is Post-Traumatic Stress Disorder (PTSD). PTSD is a mental health condition that results from exposure to a traumatic event which triggers an

emotional reaction (American Psychiatric Association, 2013; D'Andrea et al., 2011). Development of PTSD can occur after single or multiple exposures to traumatic events. It is well cited in the literature that exposure to traumatic events increases the likelihood of developing PTSD or experiencing symptoms of PTSD (D'Andrea et al., 2011; Fowler et al., 2009; Ruchkin et al., 2007). A meta-analysis conducted by Alisic et al. (2014) discovered that 16% of trauma exposed youth develop PTSD. Symptoms of PTSD include intrusions such as flashbacks or nightmares, avoidance or numbed emotions, and hyperarousal including difficulty sleeping or hypervigilance (D'Andrea et al., 2011; Fowler et al., 2009). Persistent thoughts regarding a violent incident, the perpetrator of violence, and potential future incidents can often flood the minds of those who experienced the trauma (Jennings-Bey et al., 2015). A history of experiencing traumatic events was found to be a strong predictor for both PTSD and MDE (Major Depressive Episodes) (Zinzow et al., 2009).

These symptoms can be faced by all that are connected to the victim (Jennings-Bey et al., 2015). Alisic et al. (2014) found that exposure to interpersonal traumas (e.g., violence, war, or terrorism) resulted in higher rates of post-traumatic stress disorder as compared to non-interpersonal trauma exposure (e.g., natural disaster, accidents, life-threatening disease). Therefore, exposure to urban interpersonal violence can increase the likelihood of developing serious psychological effects. Interviews conducted with those who have been exposed to violence indicate that families and community members who were not directly involved in the violence displayed symptoms of posttraumatic stress (Harden et al., 2015). Whole communities must recover from traumatic events. The community can be very stressed, overwhelmed, and cognitively or emotionally impacted. This can result in communities feeling numb, failing to believe that the traumatic event happened, expressing hysteria, or even having mental breakdowns (Kellermann, 2007).

Community trauma can easily go unnoticed as few studies have highlighted the effects of trauma beyond the individual. The Prevention Institute is one of few to discuss in detail the issue of community trauma. In their 2016 report, they propose a framework regarding the impact that trauma has at the community level. Trauma can have an impact amongst three main areas: the social-cultural environment, the economic environment, and the physical environment. The symptoms of community trauma that can be seen within the social-cultural environment include, breakdown of social relations, damaged social support systems, decreased social cohesion and an increase in delinquent or unhealthy behaviors (Pinderhughes et al., 2016). A second component is the physical environment which displays symptoms such as concentrated poverty in urban spaces, unhealthy or deteriorating environments, and an increased availability of alcohol or other unhealthy products (Pinderhughes et al., 2016). Lastly, the economic environment often shows symptoms of community trauma that include continued poverty over generations, higher levels of unemployment, lack of employment opportunities, and lack of investment in areas including the relocation of jobs or businesses (Pinderhughes et al., 2016). These issues, if not prevented, can potentially lead to additional problems for communities and feed the cycle of violence. These issues can also reduce the resiliency of a community and neighborhood in the aftermath of violence which is essential to revitalizing a community after trauma (Pinderhughes et al., 2016). It is easy for these components of a community to be separated from trauma resulting from violence, yet they can intensify traumatic effects and fuel violence through what has previously been discussed as neighborhood strain and disadvantage.

These three main areas have also been highlighted within the criminological literature around violence. Neighborhoods that are experiencing concentrated disadvantage, disorganization, poverty, high unemployment, less opportunities and resources, low social control, among other issues, have higher levels of crime including violence (Agnew, 1999; Shaw & McKay, 1942).

These components are also associated with signs of community trauma. Community trauma can increase the likelihood of these issues in areas and these issues can lead to community trauma. The overlapping impact can cause these aspects to go unnoticed and unaddressed within neighborhoods.

Opara et al. (2020) conducted focus groups with Black and Latinx youth in New Jersey to understand the impact of trauma at the community level resulting from violence using Pinderhughes et al.'s (2016) framework. Youth identified effects within their sociocultural environment stating they had a lack of support and felt that people did not care about them. This extended into education as well where youth did not feel like teachers cared about them, expressing that they were just there for their jobs (Opara et al., 2020). Opara et al. (2020) identify the potential that these effects could be due to generational impacts of society such as oppression, and broken community structures. Shaw and McKay (1942) propose that within communities where violence is concentrated, there is a breakdown in informal social control. This was exhibited by youth who felt a lack of understanding and accountability in the community to trust one another (Opara et al., 2020). This lack of trust extended beyond to include law enforcement stemming from a fear of police. Youth felt that the police did not represent them and were abusive to them (Opara et al., 2020). Anderson (1999) highlights that the lack of trust within formal institutions, such as police, leads individuals to manage their problems on their own. This contributes to the violence within communities as people take matters into their own hands, committing violence and crimes, to solve issues in the community instead of leaning on other options. Opara et al. (2020) also identified a breakdown in support systems in the community and this lack of support has been found to be attributed to violence in communities (Warner & Fowler, 2003).

Trauma also was seen in the physical environment. Youth felt isolated and described feeling residentially segregated within areas that were less economically prosperous, with less

opportunities and resources (Opara et al., 2020). Abandoned houses, high presence of drug use, paraphernalia, and deteriorated roads and neighborhoods are all indicators of community trauma which the youth identified in their community (Opara et al., 2020; Pinderhughes et al., 2016). These conditions including the abundance of drugs and alcohol and less access to areas such as parks contributed to the violence occurring in their neighborhoods. Neighborhoods that have visual cues of disorder display an idea to offenders that the neighborhood does not care about what is going on and therefore encourages this behavior to occur (Sampson & Raudenbush, 2004). It can also promote violence to occur further by evoking the lack of concern for this area. Yang (2010) conducted a study to understand disorder and violence finding that they were correlated. In areas with a higher concentration of violence, the area was also experiencing social disorder (Yang, 2010). This social disorder can include a lack of collective efficacy or a lack of social control which both have been linked to crime in communities (Sampson & Raudenbush, 2004; Shaw & McKay, 1942).

These conditions further led to negative future outlooks and emotions including feelings of hopelessness and abandonment (Opara et al., 2020). Lastly, violence impacted the educational and economic environment for these youth. They felt that the only way to succeed and do better was to leave the area (Opara et al, 2020). Experiencing violence affected all areas of individuals' lives and the community at large not only emotionally and physically, but also by interfering with daily life. Violence has an impact on the daily activities of residents in these communities by restricting the movements around the community such as walking to school and overall lack of safety (Harden et al., 2015). This desire to leave the area as the only solution to the problem exists because of the overlapping and collateral sources of strain within individuals' lives. Engagement in violence does not fall on individual level choices but instead on situational and environmental conditions that influence and lead to this behavior (Agnew, 1992; Agnew, 1999; Anderson, 1999; Shaw &

McKay, 1942).

Research has found that violence can have a serious impact on those who have been exposed as victims, witnesses, and who have heard of violence occurring (Ruchkin et al., 2007). Rosenthal (2000) found that evidence of repeated exposure, both being a victim and witnessing violence, was significantly associated with development of trauma symptoms (anger, depression, anxiety, and dissociation) in late adolescence. Witnessing violence was more associated with the development of anger while being a victim was more associated with development of depression (Rosenthal, 2000). A meta-analysis conducted by Fowler et al. (2009) found that victimization led to stronger internalizing effects (i.e., symptoms of depression and anxiety) than just witnessing violence or hearing about it. Witnessing violence (i.e., threat of a weapon or beating) was a strong predictor of PTSD and MDE (Zinzow et al., 2009). Victimization, witnessing, and hearing about violence all predicted the presence of PTSD (symptoms which included measures of flashbacks, hypervigilance, avoidance, and other diagnostic criteria) (Fowler et al., 2009).

Proximity to exposure or method of exposure seemed to vary the outcome as well. Closer exposures and victimizations were more likely than witnessing or hearing about the situation to be related to externalizing symptoms (Fowler et al., 2009). Being closer to the incident (e.g., incidents occurring at home or knowing the person victimized) was a stronger predictor of PTSD and MDE (Zinzow et al., 2009). Lifetime exposure to violence led to externalizing effects because of cumulative or chronic exposure whereas recent exposure was found to lead to stronger internalizing effects and PTSD (Fowler et al., 2009). There is overlap between being a witness and a victim of violence where studies have shown that witnessing community violence is strongly correlated with being the victim of violence (Foster et al., 2004; Rosenthal, 2000). This is

important because in Rochester, violence is concentrated within certain areas of the city. Not all residents within the community are direct violence victims, however, there are likely many residents who witness the violence that persists. These individuals are also at risk of experiencing trauma. Additionally, the type and amount of exposure to violence leads to varying symptoms. Individuals living within these communities can feel emotions such as anger as a result of the neighborhood disadvantages that they experience (Kubrin & Weitzer, 2003). Anger can in turn lead individuals who were not involved in the violence to be involved either as a witness to the act, a community member who is bothered by the violence, or family members who live in the community and may be involved out of defense for someone else (Kubrin & Weitzer, 2003). Additionally, victimization and witnessing violence were both strong indicators of externalizing effects (i.e., behavioral problems, such as aggressive behavior, delinquency, and other measures of acting out) (Fowler et al., 2009). This too can explain how the existence of violence in communities can fuel other violent acts to occur, and the overlap between victims and witnesses, as a result of exposure to violence and additional strain (Agnew, 1992; Agnew, 1999). Furthermore, through the various forms of retaliation, third parties can get involved, and this can lead to witnesses of violence becoming victims (Jacobs, 2004).

Although there are many efforts to reduce violence and target youth to deter them from engaging in violence, there are less efforts to manage the trauma that results from violence exposure. It has been noted that children living in urban areas are disproportionately exposed to adverse experiences or traumatic events, such as violence, which are linked to developing symptoms of trauma (Lynn-Whaley & Sugarmann, 2017). Finklehor et al. (2015) found that experiencing one type of violence increased the likelihood that the youth would be exposed to another type as well. Almost half of their sample reported multiple exposures within one year (Finklehor et al., 2015). Although not all youth may be exposed to more traumas than just

community violence, any additional exposures can add to the trauma and create additional distress and problems (Finklehor et al., 2015). This occurs frequently within neighborhoods that are already experiencing high levels of disorganization, disadvantage, and strain (Agnew, 1992; Agnew, 1999; Shaw & McKay, 1942). Neighborhood conditions and situational factors can create an added level of trauma and stress that can create additional problems. This exposure to community violence has been correlated to the development of trauma symptoms including anxiety, depression (Ruchkin et al., 2007) and PTSD (Fowler et al., 2009; Lynn-Whaley & Sugarmann, 2017; Ruchkin et al., 2007). Being a witness to violence predicts the development of psychological responses where 7% of those who witnessed community violence had PTSD prevalence and 11% of those who witnessed community violence had MDE (Zinzow et al., 2009). Violence that is concentrated amongst certain communities creates a space where the residents who may not be involved in what is occurring are experiencing the effects.

The prevalence of violence exposure is important to the discussion of trauma. In a sample of college students in New York City, researchers found that two-thirds of the sample had been a violence victim at least once and almost all the individuals had witnessed at least one incident occur over a three-year period (Rosenthal, 2000). Additionally, half the sample had been a victim of 1 to 3 types of violence (Rosenthal, 2000). In a sample of youth 0-17 years old, 18.4% reported witnessing a community assault within the last year (Finklehor et al., 2015). Nearly 60% of youth ages 14-17 reported they had witnessed a community assault and about 13% had been exposed to shootings in their lifetime (Finklehor et al., 2015). Zinzow et al. (2009) found that 38% of youth ages 12 to 17 in their sample had reported witnessing community violence. They calculated this to equate to almost 10 million US 12-17-year-old adolescents who have witnessed some dimension of community violence (Zinzow et al., 2009). Seeing someone seriously assaulted to the point of seeking medical attention was the most common form of witnessed violence (28%) and 19%

witnessed someone threatened with a weapon (Zinzow et al., 2009). The prevalence of violence exposure for youth is important due to the developmental stages they are still going through. However, as an individual get older, the more likely they are to be exposed to community violence (Finklehor et al., 2015). This has implications for understanding the prevalence of trauma in the community which begins at a young age and likely continues to affect individuals throughout their lives. Furthermore, as prevalence of exposure increases it is likely that the effects of trauma will also increase, if not addressed.

Rich and Grey (2005) conducted a qualitative study interviewing young black men who were recently hospitalized for a shooting, stabbing, or assault ages 18-30. Due to hospital recruitment of severe injury, 59% of the participants were shot while 35% were stabbed, it does not appear that any assaults were analyzed (Rich & Grey, 2005). About 42% of the participants reported they were victims in the past obtaining a serious injury (Rich & Grey, 2005). These victims were experiencing chronic trauma and the results of multiple exposures to trauma can be even more severe. More than three-quarters of the participants had some type of criminal history (arrest or incarceration) (Rich & Grey, 2005). Involvement with the criminal justice system can also create traumatic symptoms due to the conditions that individuals face through this experience. Participants also discussed the trauma they experienced and the symptoms they have. It was found that 65% of them have PTSD and many others were assessed for mental health illness (Rich & Grey, 2005). Likely these symptoms were developed over time and after repeat exposure. However, individuals who have been violence victims or witness violence even a single time are at risk of experiencing trauma.

In Rochester, research shows that there is a concentration of violence in certain areas (Altheimer et al., 2013). Normalization (i.e., habituation) and desensitization can result from this concentration in communities (Di Tella et al., 2019; Gaylord-Harden et al., 2016; Ng-Mak et al.,

2002). Research shows that the more often someone is exposed to violence, the more normal it becomes and the less sensitive they become to it (Gaylord-Harden et al., 2016). However, normalizing of or less sensitivity to violence does not indicate that the someone is not affected by it. Further, these reactions can lead to additional exposure to and potential involvement in violence as well as a decreased emotional response (Gaylord-Harden et al., 2016). Violence which is regulated by the code of the streets can also contribute to the normalization of violence in communities. Two studies which conducted interviews to understand the responses of youth exposed to violence found that normalization (Harden et al., 2015; Opara et al., 2020) and desensitization were both common responses (Opara et al., 2020). Some even described that their responses went from fear to fascination by the violence, others just continued with their day as if the sounds of gunshots were normal (Opara et al., 2020). Still for others, it was hard to detach from it and live somewhere it was not occurring (Opara et al., 2020).

In Rochester, there are two sections of the city where there is a large amount of violence occurring. This concentration of violence in these areas leads to higher exposure to trauma and in turn, increased community trauma. For example, youth living in the North East area of the city, will have been exposed to 752 victims of gun violence before they turn 20 years old (RPD Open Data Portal, 2020). This does not include assaults or stabbing incidents which are far more frequently occurring. The Monroe County Department of Public Health conducts an annual Youth Risk Behavior Survey across the county and city. In 2019, this survey was conducted across the Rochester City School District and received 3,280 responses. They found that 85% of students reported they had experienced at least 1 adverse childhood experience while one-third experienced 3 or more (Monroe County Department of Public Health, 2019). Further, 31% reported they had witnessed someone get shot, stabbed, or beaten in their neighborhood (Monroe County Department of Public Health, 2019). This has an immense impact on both the children in these areas who are

still developing cognitive and behavioral skills as well as those who live in these communities and are exposed to the violence. These youth could develop any range of trauma symptoms that were discussed above. They could become numb to the numerous incidents experienced or they could have intense psychological responses which could lead to potentially more serious conditions as a result of their behavior. Further, this exposure could increase the risk that these youth are victims of or involved in violence in some way. The impact from exposure to violence can often be heightened and result from a lack of resources in the community to manage this trauma. In addition to the trauma from chronic violence exposure, these youth are experiencing community strain and neighborhood disadvantage. Furthermore, any mechanisms put in place by communities to end such violence can be deteriorated by the normalizing of it occurring and the street culture in place.

Risk Factors for Traumatic Symptoms

There is variation in trauma symptoms and development of PTSD across groups. It is well documented that females are more likely than males to exhibit symptoms of and develop PTSD (Alisic et al., 2014; Foster et al., 2004; Horowitz et al., 1995; SAMHSA, 2014; Zinzow et al., 2009). Males are more likely to witness violence in the community (Finklehor et al., 2015), be victim to violence, and engage in violent acts (RPD Open Data Portal, 2020; Ruchkin et al., 2007). However, in Rochester, 52% of the residents are female (US Census Bureau, n.d.) which may indicate that females are likely to be witnesses to violence in the community. This could be as a significant other, sister, grandmother, mother, or a friend. Therefore, the concern around exposure to violence and the symptoms that result should be considered regardless of gender.

Development of traumatic effects can also vary by race and ethnicity specifically due to differences among exposure. The research on this topic is mixed, with some finding that there are racial differences in the development of trauma symptoms (e.g., PTSD) and others failing to find

differences (Asnaani & Hall-Clark, 2017; Sayed et al., 2015). Fowler et al. (2009) failed to find any significantly strong relationship between race and mental health outcomes. They proposed that although black individuals are exposed to community violence at disproportionate rates, it may be that there are mediating factors to reduce these mental health outcomes (Fowler et al., 2009). The disproportionate rate of violence exposure indicates that black individuals and black communities are at an increased risk of developing trauma symptoms as a result. Development of PTSD is dependent upon the type and rate of exposure (Roberts et al., 2011). Roberts et al. (2011) found that as compared to white respondents, black respondents had a significantly higher prevalence of PTSD. In their national sample, whites had a higher exposure to all traumatic events, but black individuals were more likely to be exposed to violent assaults (Roberts et al., 2011). Additionally, blacks had a higher risk of PTSD (Roberts et al., 2011). Black individuals are exposed to community violence at higher rates, are disproportionately exposed to other types of trauma, and reside in areas characterized by other disadvantage that place them at increased risk of developing trauma symptoms.

Managing Community Trauma

One of the first ways to managing community trauma is being educated and aware of the prevalence of trauma. Institutions, agencies, and individuals that have the tools to identify, discuss, and treat trauma can assist at the individual and community level. Further they can work toward reducing the potential for retraumatization to occur (SAMHSA, 2014). Often systems and institutions can retraumatize individuals even unintentionally. For example, individuals who have been violence victims previously may be at further risk of retraumatization not only from a new injury, but also from hospital visits or police interactions that remind them of those prior situations. Being aware of the prior traumas that individuals or groups of individuals have faced is important

to managing trauma (SAMHSA, 2014). One of the ways to manage trauma and reduce retraumatization is through trauma informed care (TIC).

Trauma informed care is an approach to treatment that considers the lasting impacts of trauma and reduces the potential of retraumatization (SAMHSA, 2014). Harris and Fallot (2001) developed the first protocol around trauma informed care with five main elements: safety, trustworthiness, choice, collaboration, and empowerment. While it has been utilized on marginalized groups such as those with mental illness (Hall et al., 2016; Mihelicova et al., 2018) and prison populations (Jewkes et al., 2019), it has not been applied to victims of interpersonal violence. However, the applicability to this population is possible and should be considered. This approach has been applied to domestic violence populations (Wilson et al., 2015). A content analysis of this application revealed six important elements: promoting emotional safety, restoring choice and control, facilitating connections, supporting coping, responding to identity and context, and building strengths (Wilson et al., 2015). Although these elements are specific to domestic violence, they can be expanded to other populations. This is through highlighting the goals of trauma informed care, which is not to treat the trauma directly but to provide awareness to the issue of trauma. In turn, this can manage the lasting impacts of trauma exposure and reduce the potential for further traumatization.

Although the popularity and applicability of trauma informed care has been growing, it still has limitations. It can be assumed that individuals that work in institutions that work with trauma populations have adequate training. However, a survey of emergency department (ED) staff revealed that 90% of them had not received training on trauma informed care despite working with trauma on a regular basis (Hoysted et al., 2017). ED staff are in a crucial position to target the traumatic impact and reduce the effects of trauma due to being the point of contact for treatment after violence occurs. Surveys of ED staff also reveal a lack of awareness for the implications of

traumatic injury on the developments of the effects of trauma such as post-traumatic stress (Hoysted et al., 2017). This has a direct impact on the potential for retraumatization, revictimization, and further long-term negative outcomes.

To expand this type of care to impact the whole community, training would need to occur at the organizational, agency, and institutional levels. However, there are barriers to this type of implementation of new skills. Currently, there is an overall lack of training for many agencies around topics that would be helpful to their daily work (Hoysted et al., 2017). Secondly, time is a constraint identified by staff of a variety of service providing groups including ED staff (Hoysted et al., 2017) and those working with child welfare groups (Kramer et al., 2013). Many agencies do not have the time to devote to new trainings due to busy schedules (Hoysted et al., 2017) and heavy caseloads (Kramer et al., 2013). Other barriers include the lack of resources (Kramer et al., 2013). Implementation of training to expand practitioner knowledge and create space for trauma informed care practices may be most successful if buy in is achieved from and training begins at the supervisor level (Kramer et al., 2013), which is not always possible. Further, the current practices in place at the institutional level restrict potential new policies or practices to emerge. For example, in the medical field much of the practices are scripted and do not allow room for open ended questions (Novick, 2018). Trauma informed care provides the space for individuals to tell stories and open up about experiences that without the proper questions, can go unnoticed. Wolf et al. (2014) suggests that trauma informed care can also be helpful to staff among community agencies. Traumatic events can affect all who are connected to the incident that occurs, even hearing about it can cause trauma symptoms. Applying these same practices at the community level can be helpful to managing vicarious trauma as well. Community organizations who are directly involved in violence reduction efforts can benefit from this type of training too, but they often face similar constraints as the institutions.

Solution Focused Trauma Informed Care (SFTIC) takes a trauma informed approach to care with the addition of being solution focused or allowing the individual to direct the outcome (Krause et al., 2018). Solution focused approaches tend to entail a focus on language and using the right language to assist the individual in discovering the solution to the situation (Krause et al., 2018). This includes asking directed, yet open ended, questions that allow the individual to be in control of the situation. Utilizing the wrong language such as asking "why?" instead of "how?" can unintentionally retraumatize individuals (Krause et al., 2018). Combining trauma informed care with solution focused care provides the tools necessary to be trauma informed and implement the goals of trauma informed care in practice.

Following the principals set by Harris and Fallot (2001), these questions may be directed toward achieving the goals of these principals. For example, a SFTIC approach to ensuring safety may include directly asking individuals about how safe they feel and what would make them feel safer (Krause et al., 2018). It can also include allowing individuals to take the lead on the conversation to ensure that providers are not moving too fast and emotionally harming them. These questions can also be helpful for building trust, allowing individuals to set goals for the relationship between staff and clients (Krause et al., 2018). For violence victims, this is one of the important elements as staff work to address trauma. If trustworthiness is not present, likely information would not be shared and trauma can easily go unnoticed. SFTIC also promotes person centered approaches that leave the individual in charge of what happens for them while service providers guide them along the way (Krause et al., 2018). This is the approach of giving choice in how the interactions move forward, and how the solutions begin. Collaboration is another key element achieved by ensuring that the relationship between staff and client is mutually achieving the goals. Staff that do for the individual instead of with can undermine this element of SFTIC which can cause harm later, making the individual feel like they cannot do it on their own (Krause

et al., 2018). Lastly, empowering individuals is one of the more important elements. Empowerment assists with providing the individuals with the awareness of their own skills and capabilities to overcome and achieve their goals (Krause et al., 2018).

Trauma informed practices are evidence based and proven to be effective in managing trauma. Findings from an analysis of the Truth N' Trauma project indicate that a trauma informed, and restorative framework is an effective method at reducing the impact of trauma (Harden et al., 2015). They found that those in the treatment group had significant average differences for 41 outcome measures regarding school, community, family, experience, and self as compared to the control group who only had 4 (Harden et al., 2015). Specifically, trauma informed cognitive behavioral therapy is one treatment method that is evidence based and has been found to be a proven practice for treating PTSD in youth. The World Health Organization also recommends cognitive behavioral therapy (CBT) that is trauma informed for treatment of traumatic stress symptoms (American Psychological Association, 2019). Recently, a benchmark study was conducted to understand the impact that trauma-focused cognitive behavioral therapy provided to youth (ages 5-19) from 2013-2016 across 15 Philadelphia behavioral health agencies (Rudd et al., 2019). They found modest significant improvements in PTSD symptom severity, functional impairment, and problem severity (Rudd et al., 2019). The population that the treatment is applied to can influence the outcome. Rudd et al. (2019) applied this approach to a black, low income, urban group of youth and found that the effect size was smaller than other studies. Trauma-focused CBT was created to manage past trauma and when applied to an urban setting, it is much more likely that these youth are experiencing ongoing traumas such as community violence as compared to other samples. Therefore, although the training is not intended to manage ongoing trauma, it did have a positive impact on this population.

Conclusion

Trauma is well documented and studied in the literature. However, community trauma is less discussed and often hard to identify within communities. Similar to individual trauma, it can go unnoticed. Yet, it is important that communities work not only to identify the trauma but also to manage it. Trauma can impact the emotional, physical, behavioral, and psychological wellbeing of individuals and communities. These problems can improve overtime but can also worsen with repeat trauma exposure and the lack of management of symptoms. Community trauma symptoms can cause persisting violence amongst communities which can accrue further problems.

Communities may experience symptoms of trauma in the physical environment, the economic environment, and the cultural environment. Although the identification and measurement of community trauma can be difficult, there are ways to manage it through community organizations, service providers, and institutions by providing them with trauma informed approaches. These approaches are important to violence efforts because without them violence can continue and be pervasive among communities. These approaches can not only help those directly affected by violence but can reduce vicarious and secondary trauma effects as well. One such program that has begun in Rochester to manage the trauma that individuals experience as a result of violence is CERV. CERV, Community Engagement to Reduce Victimization, is a hospital-based violence intervention program that works to reduce retaliatory dispute related violence within the City of Rochester. CERV uses existing resources within the community and local community organizations to manage the trauma that is faced by victims as well as those connected to the victim. In turn by managing this trauma, CERV works to reduce violence victimization. Future papers will discuss CERV and the research that has been conducted around this project to identify the gaps in services that are experienced following a violent injury and the resulting trauma at the individual and community level.

Chapter 4

The Upward Battle: Life After Victimization

Introduction

Traditionally, violence has been targeted by law enforcement, yet recently there has been a shift to treating this issue as a public health problem. This shift takes into consideration the psychological, physical, and emotional impact that violence has on individuals, communities, and institutions. Additionally, this has led to non-law enforcement alternatives to addressing violence in communities which have come to the forefront taking into consideration the varying degrees of engagement in violence. One of these approaches is CERV, Community Engagement to Reduce Victimization. CERV is a hospital-based violence intervention program that works to prevent retaliatory dispute related violence in the City of Rochester. CERV partners with a local hospital, Rochester General Hospital, and four community organizations, Pathways to Peace, Rise Up Rochester, Save Our Youth, and United Christian Leadership Ministry. This intervention identifies violence victims (i.e., blunt force trauma, gunshot wound, and stab wound) at the hospital who are at risk for further victimization and provides them with a coordinated trauma-informed response. It is through this project that interviews with violence victims and their surrogates (e.g., family members) have been conducted.

This paper will present interview findings using customer journey mapping. The goal of this approach is to understand the patient experience with different systems and institutions. Understanding the patient experience can expose the potential gaps in care that exist after a violent injury. Exposing these gaps in care can inform policy and practice changes at the system and institutional level to fill in potential gaps. This paper works to address the research question: How are violence victims and surrogates treated after victimization? Advanced knowledge around the experiences victims and surrogates have after victimization is important because this treatment can determine whether violence continues in these situations and impact the short and long-term effects of these situations.

Sample

Three groups of individuals were interviewed as a part of this project: (1) victims who were connected to CERV upon hospital release, (2) surrogates of victims who were connected to CERV, and (3) victims who sought care at a Rochester hospital but were not connected to CERV. Overall eligibility for these injuries is as follows: the victim was treated at the hospital due to a blunt force trauma, stab wound, or gunshot wound, their injury was not the result of a domestic violence related incident, and the victim is older than 18 years of age. These individuals themselves or their connected victim all sought treatment for a violence injury at a local area hospital sometime during the project timeframe, June 2019 to March 2021.

Methods

Participants were recruited through project CERV, partner organizations, and the project coordinator. Participants were identified through a convenience sample of those that sought treatment at two local hospitals. Semi-structured interviews were conducted at least 30 days after hospital discharge. Interviews were conducted in person until the COVID-19 pandemic began. Starting April 2020, all interviews were conducted over Zoom. All interviews were recorded either with an audio device in person or with Zoom. Any video files were destroyed, and audio files were transcribed for analysis. All interviews resulted in a completed written memo conducted by the researcher. Interviews were voluntary and consent was obtained. Participants received a $25 Visa gift card for compensation. Interviews were conducted by a research assistant and the CERV project coordinator and lasted approximately 30 minutes to 1 hour. However, to reduce bias and interviewer influence, the CERV project coordinator stopped conducting interviews and the project's principal investigator stepped in to conduct them alongside the research assistant.

Interviews were guided by the customer journey mapping framework. Three interview

guides were utilized for each group (see Appendices A, B, and C). Interviews attempted to follow a linear map through four main stages representing time: (1) Initial Incident (pre-treatment), (2) Hospital Treatment, (3) Post-Hospital Release, (4) Post-Service/Program. Each stage has a series of touchpoints to various institutions including, the hospital, law enforcement, outside service providers, and street outreach groups (i.e., CERV and the community partners). Interviews highlighted interactions with each of these systems to understand gaps in care.

Touchpoints and channels are found within the stages of the customer journey. Touchpoints are interactions within each of the systems mentioned above. Channels are the mechanisms in which victims were connected to a touchpoint. Channels included calling 911, being driven to the hospital or taking an ambulance, how someone was informed of project CERV, among others. Touchpoints and channels can often overlap which makes them complex. There was no limit to the number of channels or touchpoints that a victim or surrogate could have. Touchpoints and channels are the element of location, where, how and with whom interactions occurred. Interviews asked questions regarding feelings and emotions at each of the stages. Emotions are crucial to understanding the customer experience. Nearly parallel to the concept among emotions revealed were thoughts. Thoughts were defined as what the individual was thinking about and often included actions or planned activity. Emotions and thoughts are important to the element of experience quality. The last focus of interviews was on their experience. Experiences were anything that the victim described occurring at that stage including their ride to the hospital, how surrogates were notified of incidents, hospital staff treatment, whether their needs were met, and whether they would recommend the hospital or the services to other violence victims.

Interviews were analyzed using NVivo qualitative analysis software. All elements described above for customer journey mapping were included in the coding process. One CERV victim interview was chosen for a pilot. This interview was coded and then codes were discussed

by all researchers to identify missing areas and ensure that coding was consistent amongst the important areas of stages, touchpoints, channels, and other elements that came through (e.g., trauma, CJ system involvement). After the pilot was discussed, all remaining interviews were coded. All interviews followed the same coding process. First, interviews were coded based on the various stages. For example, an interview was read through one time and each section that represented the hospital service stage was coded as a block of text representing "hospital". All interviews had an initial incident, hospital stage, and post-hospital release stage. Non-CERV interviews did not have a post-services/program stage because receiving services after the hospital did not occur. After the stages were coded, line by line coding took place to identify various aspects of the experiences. There was no limit to what could be coded within this stage. However, there was a focus on emotions, thoughts, experiences, interactions with the touchpoints, and channels to those touchpoints.

Once coding was completed, a coding memo was written by the researcher. Once all the major areas of touchpoints, channels, and emotions were coded, other areas were coded and often those aspects led to the creation of themes. Theme development occurred naturally for some of the interviews but was enhanced by looking at the number of times a code appeared in interviews and was referenced across files. Interviews were coded while new victims were being recruited for interviews and areas which were felt to be missing were asked in future interviews to supplement missing areas amongst other interviews. For example, the initial interviews conducted did not focus as heavily on emotions, sometimes forgotten as the participants steered the interviews, so this was important in future interviews to ensure it was being mentioned and gathered at every stage. This also ensured that saturation was being reached.

Lastly, the final product of this methodology is a visualization of the participant journey (Crosier & Handford, 2012; Panzera et al., 2017; Rosenbaum et al., 2017). Maps were created after

coding was completed and often helped to identify themes. First, individual maps were created for all participants and then combined maps representing the victim and surrogate journey were created. These combined maps highlight the main themes. Figure 1 below presents the victim journey and figure 2 presents the surrogate journey. The horizontal axis represents time (i.e., stages). The vertical axis shows location and quality through touchpoints, channels, thoughts, emotions, and experiences including both positive or negative emotions. The path at the bottom represents all the points of contact participants had.

Findings

Seven victims, four surrogates (including a sister and three mothers), and one non-CERV victim were interviewed and included in this analysis (See table 1). Most victims had been shot while the remaining were stabbed. Although most violence victims are male, interviews were conducted with mostly female victims. Many of the victims were also black. All surrogates were female and had a familial relationship to the victim.

Table 1: Participant Information

Case #	Type of Individual	Name	Victim Injury	Victim Gender	Victim Race	Victim Age	Date of Interview
1	Victim	Alexandra	Gunshot Wound	Female	Black	29	2/28/2020 5/13/2020
	Surrogate	Brianna					2/28/2020 5/13/2020
2	Victim	David	Gunshot Wound	Male	Black	19	2/19/2020
	Surrogate	Makayla					5/20/2020
3	Victim	Anthony	Stab Wound	Male	Black	25	5/27/2020
4	Victim	Destiny	Gunshot Wound	Female	Unknown	21	3/3/2020
5	Victim	Cameron	Stab Wound	Male	Black	20	3/11/2020
6	Surrogate	Edith	Gunshot Wound	Female	Black	20	4/2/2020
7	Victim	Ciara	Stab Wound	Female	White	29	10/23/2020
8	Victim	Maya	Gunshot Wound	Female	Unknown	36	12/18/2020
9	Surrogate	Tia	Gunshot Wound	Female	Black	20	12/4/2020
10	Non-CERV Victim	Caleb	Gunshot Wound	Male	Unknown	23	9/2/2020

The victim journey is shown in figure 1. The victim experience from initial incident to hospital treatment to post-hospital release to post-services/program revealed eleven themes, *unmet hospital needs, retaliation, lack of aftercare/follow up, safety concerns, need for a cool down period, instability, inconsistent law enforcement response, hopelessness, experiences of trauma, need for support,* and *exhaustion.* The surrogate journey is shown in figure 2. Surrogates revealed similar themes as victims but from a different lens. The most common emotions at each stage are presented using emojis. Victims described a variety of emotions so the top four were included, whereas surrogates did not describe as much variability in emotion and two were sufficient. The path includes the events most participants experienced, although participant paths were unique.

Figure 1: CERV Victim Journey Map

Stages	Initial Incident	Hospital Treatment	Post-Hospital Release	Post-Services/Program
Touchpoints /Channels	❖ Incident Occurs ❖ Fail to Call 911 ❖ Transport to Hospital ❖ Private vehicle to RGH, Ambulance to Strong	❖ Arrive at ED. ❖ Greeted by someone (unclear who) ❖ Treated by hospital staff ❖ Consent to Services ❖ Outreach Visits ❖ Police Interact at hospital ❖ Released back into community	❖ Some victims went home. Others needed temporary safe housing options. ❖ No follow up medical appointment ❖ Communication with outreach staff ❖ Interaction with Services ❖ Services provided to individual to assist. ❖ Police don't engage them again. ❖ Healing from injury.	❖ Doing better physically ❖ Still looking for safe places to live, engagement with other services. ❖ Long-term interaction with CERV through phone calls/text messages.
Thoughts	Am I going to die? I'm scared.	Retaliation: concern around revenge, retaliation, going to harm someone else or that someone would come harm them.	Am I safe? Do I have somewhere safe to live?	The only way to move forward and be safe is to leave Rochester. CERV was helpful to have someone to talk to, support them, and care about them. Some mentioned this support was a turning point for them and things are better because of that. Without it, they would still be involved, potentially retaliating
Emotions				
Experiences	• Private vehicle drove to hospital. • Variation in calling 911. Some did not, some knew someone else called on their behalf.	• Hospital did not meet their needs. Rushed, did not acknowledge seriousness of their injury, did not give proper care, did not update them on their own health status. • Almost all victims spoke to an investigator at the hospital, but these interactions were not viewed positively.	• Hotel stays were very beneficial, provided safety and time to think. Without them, participants had no where safe to go. • Outside service providers created barriers to care making it very difficult to get any assistance • No FollowUp Care. • Employment was affected by their victimization • LE Response after hospital release was inconsistent	• Symptoms of trauma: hypervigilance, nightmares, emotionally and mentally drained. • Still impacting their movements and lives, sleeping wherever while trying to find a place to go.
Path	Incident Occurs Victim takes private vehicle to hospital	Victim arrives at hospital Treated by Hospital staff Police Visit Outreach Visits	Released from Hospital Reconnect with CERV CERV provides hotel as temporary housing CERV assists in connecting to other services	Victim leaves safe housing Victim works to find stable, permanent housing CERV staff stay in contact with victim Injury healing, trauma impact.

Scared: 😳 Anxious: 😰 Worried: 🙁 Overwhelmed: 😩 Angry: 😠
Upset: 😟 Supported: 🥰 Frustrated: 😤 Depressed: 😞 Empowered: 🙂

Figure 2: CERV Surrogate Journey Map

Stages	Initial Incident	Hospital Treatment	Post-Hospital Release	Post-Services/Program
Touchpoints /Channels	❖ Incident Occurs ❖ Surrogates notified either by other family or the victim themselves. ❖ Surrogates arrive to the hospital	❖ Arrive at ED. ❖ Greeted by Security/Hospital Staff ❖ Allowed to visit, brought by nurses to visit. ❖ Others stopped by security and not allowed. ❖ Victim consent to services ❖ Outreach Visits engages with family ❖ Police engage with surrogate & victim	❖ Communication with outreach staff ❖ Surrogates assist in care of victim . ❖ Interaction with Services	❖ Doing better. ❖ Violence did not continue ❖ Surrogate trauma impact ❖ Surrogate outstanding services they did not receive.
Thoughts	Not sure what had happened, need to get to hospital as soon as possible.	What if the victim is revictimized? Is the victim okay?	Police can't protect the victim or surrogates. Police create barriers. No one can help except CERV. CERV staff care and were there.	Need to leave to be safe . Violence really impacted the victims.
Emotions				
Experiences	• Victims called surrogates to tell them they had been victimized. • Surrogates immediately went to the hospital	• Surrogate treatment by the hospital varied. Two surrogates were not allowed into the hospital when they arrived. One mentioned they were provided information and treated well. • Surrogates did not feel victims were getting adequate treatment .	• CERV helped support surrogates and navigate services. Helped comfort them. • Surrogates responsible for aftercare of victim. • Negative interactions with police.	• Still trying to feel safe and manage trauma.
Path	Incident Occurs / Victim notifies surrogate	Surrogate goes to hospital / Victim treated by hospital staff / Police Visit / Outreach Visits	Victim released from hospital / Reconnect with CERV / CERV provides hotel as temporary housing / CERV assists in connecting to other services	Victim leaves safe housing / Try to find stable, permanent housing / CERV staff stay in contact with victim and surrogate / Injury healing, trauma impact.

Scared: 😳   Anxious: 😨   Worried: 🙁   Overwhelmed: 😫   Angry: 😠

Upset: 😞   Supported: 🥰   Frustrated: 😤   Depressed: 😔   Empowered: ☺
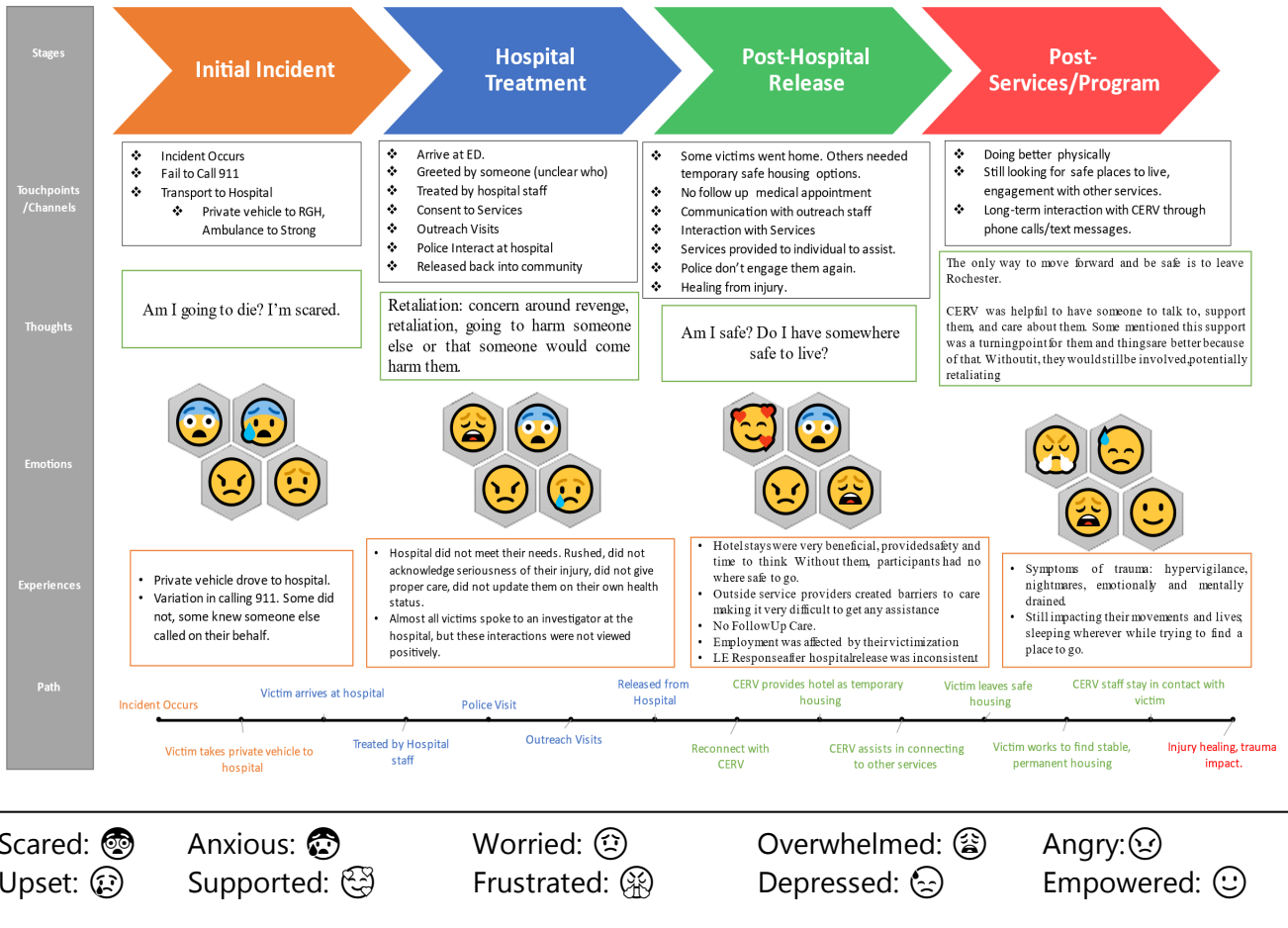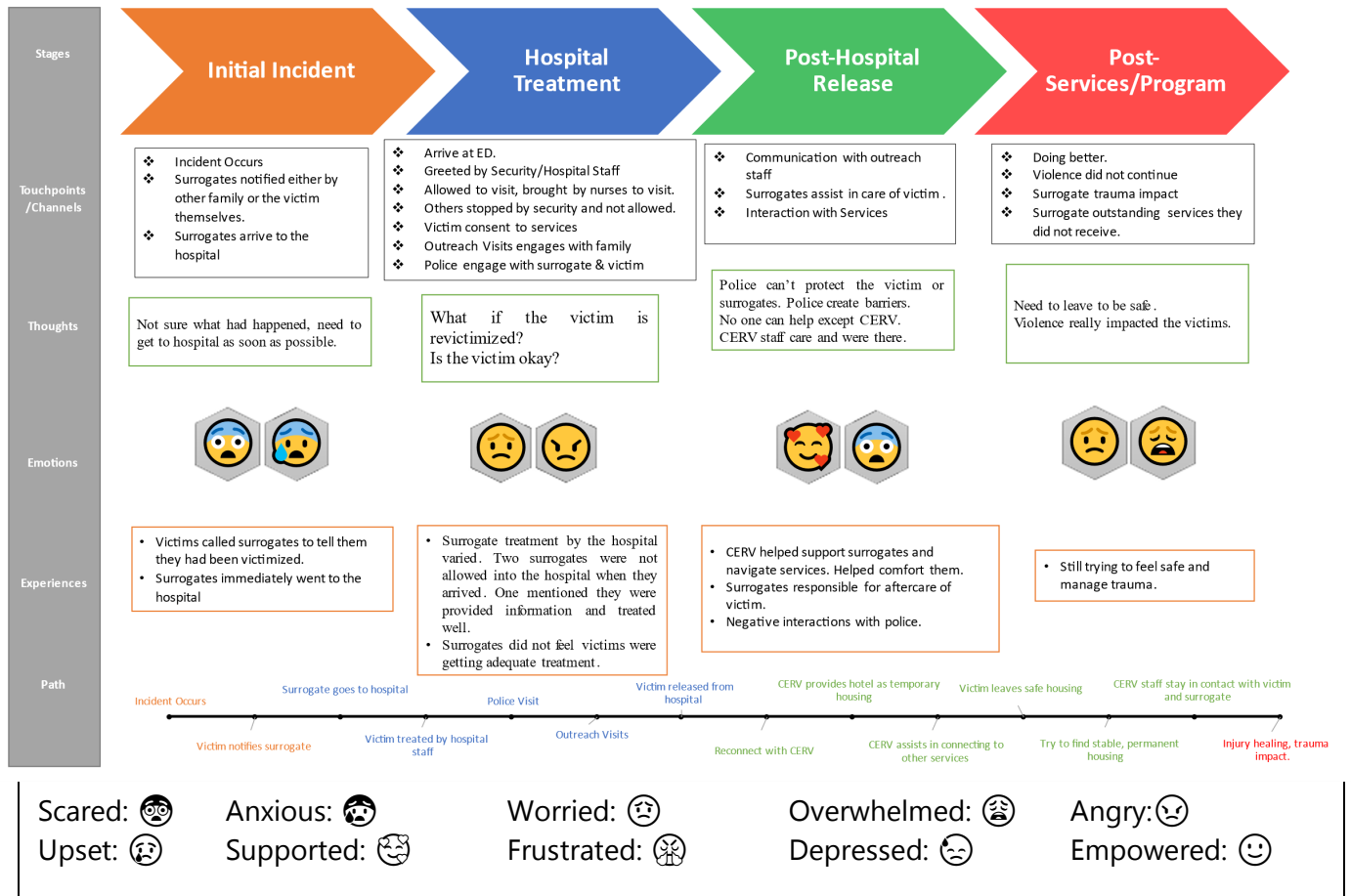
The themes are discussed in depth below by stage they occurred in. Although individuals had varying journeys and interacted with different systems, the underlying finding was that these systems continuously made life after injury challenging.

Initial Incident

All but two victims were driven to the hospital by private vehicle. This was a friend, family member, or even a random person who was nearby that drove them. One victim called an ambulance, but it took too long to arrive, and she decided to be driven there instead. The two individuals who were taken by ambulance went to the local trauma center. Not all victims called 911 when the incident occurred. When 911 was called, someone else called on the victims' behalf.

The police were notified regardless because it is hospital policy to notify police when victims arrive. Alexandra was one of the victims where someone called for help after the incident, she states, "My friend did, she went behind the store, she was so scared at that point she went behind the store and called the police." Alexandra's sister further explains the urgency of the situation. Although an ambulance was on the way for her, she jumped in a friend's car instead to get there sooner.

> Brianna: I didn't know who called 9-1-1 but I did hear there was a few people that called 9-1-1, but a friend of ours waved a car down and taking her to the hospital. That was one of her main purpose of surviving that she was drove instead of waiting for the ambulance to get there because she was internally bleeding.

At this stage, participants described emotions including being scared, anxious, depressed, and even angry. Alexandra describes "I felt myself going out, like couldn't breathe and it was dark and scary and I was scared." She further describes her fears upon arriving at the hospital, "That I wasn't going to make it, that I wasn't going to be able to make it. I telling her to tell my family that I loved them." Anthony describes his experience:

> Anthony: Well I didn't drive, my best friend was driving and me personally I was feeling a lot of different emotions, right, I was angry, I was mad, I was upset. I was a lot, I was hurt.

Caleb describes:
> Right, I was like I was in shock, when I first got shot I felt my body being weak, because when I felt the gunshot wound and I seen I was bleeding it was like I got driven there, so it was like I didn't really feel it no more, so when I got in the car my body felt a little hot and the dude was just telling me to stay up and stuff like that, just basically just telling him to hurry up. I just was telling him to hurry up and get to the hospital basically because I was freaking out basically. He was trying to tell me to stay calm.

Most of the surrogates found out about the incident that occurred from the victim themselves while one of them found out from another family member. As to be expected, this had an impact on them. Brianna describes how she felt when she received the phone call.

> Brianna: You're going to make me cry. I was distraught, that's my baby, that's my baby you know, like we have our ups and downs but I'm more like her mama so I was really hurt because I got the phone call at like 1:30 in the morning to say that yeah, my God daughter

called me.

[…]

Brianna: it was just horrible, it was like a phone call that you pray you will never get you know.

Tia further describes, "My anxiety was through the roof", when her son video called her. This also had an effect on her as she later described:

Tia: I probably could have needed to talk to someone or something but I didn't, cause that was really hard for me to actually see him on Face Time, he was screaming and hollering telling me he was shot. I really didn't take a hold so, like it did something really bad to me. I just consolidated everything in my mind, so I was just I'll make it day by day.

Hospital Treatment

The hospital stage did not leave victims satisfied with their experience as they described *unmet hospital needs*. Some of this dissatisfaction was due to the physical state of their injuries while others were due to how well the hospital staff performed their job. Ciara describes the numerous elements that led to her overall dissatisfaction with the hospital treatment she received.

Ciara: No and I didn't receive no pain medication, nothing, no after care instructions, that's what I'm saying, I don't feel they take care of people. I got stabbed four times and basically was like oh you're stitched up, time to go home.

Ciara did not feel that a couple of hours was enough time to properly care for her injury. She is not the only one whose unmet needs were based on the medical treatment that they received. As described by David when asked if the hospital staff met his needs:

David: Not really. If you ask me I don't think they did because it took them that long to do anything. It took them mad long to even come and clean it or even attend to it. So it was just me, my mom and my sister, we were sitting there for a while waiting for them to come and them came after 35 or 45 minutes.

Interviewer: Did you trust the people at the hospital?

David: Yeah I did, but they was weird, like they took too long. I feel like they didn't really give a fuck, if you ask me.

[…]

David: There was even a hole in my leg and my mom said that, […] even if it was that small they was supposed to stitch it together and they didn't do that, they just left a big ass hole in my leg. They just cleaned it out and left a hole in my leg, they didn't stitch it up, they didn't do none of that, they just left it.

Caleb echoes the frustration around his injury after he gets home from the hospital as well stating, "Everybody else they're back out living their lives. I'm the only one with a bullet still stuck in me.". Other people were injured in the same incident and it seemed to bother him that his injury left a more lasting impact.

The perception of how well the hospital met the needs of violence victims did not appear to be dependent on which hospital victims went to. There was satisfaction and dissatisfaction across hospital systems. Destiny took an ambulance to the local area trauma center and she was also dissatisfied with her experience. She was both a victim and a surrogate as multiple people were injured in the incident; however, she is included as a victim in the journey map. She discusses her experience:

> Destiny: No. They was so in a rush, they probably didn't notice it but that was bad in a room because they was so in a rush and so overwhelmed, five people just came in from getting shot, so they was so overwhelmed and so confused, like where are the parents at, where's the adult. I was the adult but I was in the same situation so I can't be there with them at that moment because I was in the same situation. So they were so overwhelmed trying to find out who was who and who go with who and then trying to make sure nobody else came in to retaliate again, it was just not paying attention to what we had to say at all.

Destiny was also placed in a bed in the hallway, and she did not feel she was safe after the violence that had resulted in her hospital stay. Caleb discusses his frustration with the same hospital feeling that they did not really care about his life and his injury.

> Caleb: I mean no, nah, I'm not going to lie, no I don't, because literally after this situation and then going in there I really see how people die and I kept saying that, I really kept saying that that's how people die. They don't even care I don't think, I really don't, it's just a job, they come and get money for it, they don't really care.

Some victims described shocking initial interactions with the hospitals they arrived to describing that staff did not initially believe that they were injured. This is described by Caleb and Ciara. For Ciara even after they realized she was stabbed, they were upset that the injury was not as serious as was described by the victim.

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Ciara: I came in and told them I'd been stabbed and I don't know they just, it's been a while but basically they just sat there looking at me, and I was like I've been stabbed, hello, like I need some help. Then when they were taking me to a room I don't know they, yeah they stitched me up but they kept hitting my injuries like just tossed me around like a ragdoll instead of like caring for me like they should.

[…]

Ciara: They took me immediately because I didn't know if I was stabbed in my stomach or not, as soon as they noticed I wasn't stabled in my stomach they were treating me like shit. They were saying I could have waited in the waiting room for that.

This was not Ciara's first negative experience at this hospital. These experiences left a lasting impact as she states she is never going back again. Caleb also highlights how intense these incidents are when arriving at the hospital. Victims also struggle to remember who they encountered upon arriving to the hospital due to the trauma and stress they experience.

Caleb: So we pulled up and he walked me in and I'm telling them I'm shot, I'm shot, it was the people whoever was sitting there I don't know and they just were looking at me like, just staring at me and I'm like I'm shot and they was like where's the gunshot wound, I'm like put me in a bed and you see I'm shot in my back and they were oh we got a gunshot wound, came and took me and put me on the bed. Put me in the bed like and took me to the other part, I don't know what it's called.

[…]

Caleb: I don't even know who they was, I like, my mind was just, I was just in shock, I just was trying to hurry up and get seen, so as soon as I walked in there I started yelling I'm shot, I'm shot, like as soon as I came in there, so there was somebody just sitting there looking at me and then they got up once I told them I was shot in my back. I think they called people, I don't even remember, I think they called somebody and they came and that's when they brought the little bed thing and put me on the little bed.

[…]

Caleb: Once he seen that I was actually shot in my back then it was quick, like it was a rush, but I don't know if they didn't process it right, it was just so like random or something, I don't know what it was like they made out like I was speaking a different language. Then when they realized I'd been shot and the dude in the end was saying he's shot, he's shot, that's when they bring the bed.

Caleb continues to reflect on his experience. His dissatisfaction centered around the lack of information sharing that occurred from the hospital. Caleb was upset that the hospital did not tell him if he was going to be okay. Victims are feeling all different types of emotions and it is important to them to know the state of their injury.

Caleb: No actually they couldn't tell me, I don't know if they was not doing that to not scare

me or something, but they wasn't telling me nothing. […] I was asking them am I good, am I going to be okay and the lady was I'm not the nurse, or I'm not something, I can't actually tell you that and I'm like but, she said if you're responding most likely you will be okay. I don't want to hear there's a good chance, that's all they kept saying all the time, there's a good chance, just tell me yes or no, […]they was telling me I'm doing good, I'm responding still, I'm doing good, then they took my heart rate and stuff like that, but they still wasn't telling me nothing so then they took me back to the room, they took my pants off and stuff. I just kept asking them am I going to be okay, they just kept telling me to relax and all that.

Surrogates also left the hospital dissatisfied with the experience, worried that their family was not receiving the proper care and treatment. Edith describes the treatment that her son received at the hospital.

> Edith: […] it almost seemed like he was victimized again when he got there because it started seeming like the nurses and everyone once they found out he got shot they started acting like they were scared to come in the room. Like the whole treatment just kind of went in another direction where most of the time people come to the hospital they're treating them and showing some kind of compassion, well in his place it got to the point where they looked at him like he was a gang member […] the hospital started looking at him like he was a gang member or some type of involvement that caused him to get shot and that wasn't the case. But the way that they started treating him you got certain nurses that was okay with going in and giving him his treatment, you got other nurses that started backing out like they didn't want to go in the room.

At the hospital, victims also described thoughts and concerns regarding *retaliation*. CERV's goal is to reduce retaliation and near-term violence victimization. These feelings regarding retaliation and the wish to get revenge or even concern about revictimization were present. David describes:

> David: Because like at that time at first I was angry, I didn't want to hear nothing from nobody, I wanted to basically go back out and do basically the same thing that they did to me.

Alexandra describes her emotions at the hospital:

> Alexandra: A lot of stuff was going through my mind like me being shot, like I was thinking about, like I was in the hospital I didn't really want to stay there because I always had nightmares being shot and stuff, and I was thinking about like I wanted to hurt somebody for hurting me and I was like thank God I'm still here for my kids.

Anthony described his situation around retaliation. It appeared that his involvement with CERV as well as his children and how retaliation would affect them, helped with his decision.

Anthony: I wanted revenge but then I was also thinking about my child in this situation and I know I had to be the bigger person to let the situation go on account of him. So around me and Ms. Wanda talking it was more so like I just wanted to leave it all alone but then again I still had that urge to meet someone to get my revenge.

Destiny centered her decisions around faith and religion. She was unsure what was going to happen but had been feeling many emotions around her current situation. She appreciated having people to talk to as well but even with support, she was worried and confused about her situation.

Destiny: I had a lot of people to talk to about self esteem but other than that I was depressed, scared, felt like I was in a bad situation, should I retaliate or should I just do better so that this don't go farther than what it is. So I was confused, I was stuck in the middle of it, should I just turn it up or should I let it go and see how God let's this play out, so I was confused.

Surrogates were also worried about what was going to happen next for victims. Edith described the worry and fear she had around her son's safety. She tried to maintain control over the situation while her son was in the hospital even going so far as restricting the number of visitors he could have in his room. She describes her reasoning behind this:

Edith: One is he's very vulnerable so therefore you don't know who shot him and if that person that even shot him may have been able to come in and walk right through the hospital and visit and finish him off, you know, in addition to when you have a hospital so open like that anything can happen.

Post-Hospital Release

Interviews revealed a *lack of aftercare/follow up* for victims upon leaving the hospital. Some participants mentioned that they were given information but did not attend or need a follow up appointment. The lack of pain medicine provided by the hospital was mentioned by multiple victims. This was something that victims felt that they should have received and did not. The level of pain they were feeling and the lack of anything to succumb that pain led to a negative perception of the hospital treatment they received even if their injury did not require them to receive pain medicine. Not all victims received clear aftercare instructions if at all which may have

pointed out which medications they could take, if any. David received a follow up appointment, but he did not attend it.

> David: Yeah they gave me a follow up appointment but I ended up not going because I didn't need it.
> Interviewer: Okay.   Everything was healing okay?
> David: Yeah, my mom was helping me do it, like I basically was doing it on my own as far as like the actual gauze, they gave me what they could but I had to buy extra stuff.

Upon discharge most victims had to continue to care for their wounds from stopping the bleeding to cleaning the wound to ensuring they did not get infected. This often fell onto surrogates of victims. David's mother, Makayla, was responsible for his wound caretaking which included buying more supplies to take care of it. Makayla was not alone in this responsibility. Tia describes what it was like to care for her son's wound after his injury.

> Tia: I got the shakes and the shivers changing the bandages cause the size of that hole I could literally probably stick my pinky finger all the way through it if I tried to. It was just like the worst and then the thing with the pain that evening made me even, I was up with anxiety, I have very bad anxiety anyway and just to look at that and then the pain with just pulling the tape off it was hurting him so bad and I was crying at the very first maybe three times of changing the bandages, I wanted to keep it changed a lot because I didn't want him to get infection and like that, so I changed them more than they was probably supposed to be changed you know, from him getting an infection he could have lost his leg from it or just have a real bad infection throughout his body from it, so I changed them like maybe two or three times a day just to keep it clean, but they was telling me don't put no water in it, so I didn't use water, the first time I had to use water because it was so stuck on his leg and there was so much pain from me pulling it off and just seeing his face squinch up the way it did and him being a young man he didn't want me to see him in so much pain and that hurt me really, really bad.

Although this was painful for the victim with the injury, caretaking for these victims also had a huge impact on the surrogates. It was difficult, even upsetting, for surrogates to see the victims in distress. Other victims did not have anyone to assist in their caretaking, they were responsible for this on their own. Not all victims had a support system to lean on which makes it even more ideal for follow up care. Alexandra had a very serious injury and after being in the hospital for numerous days, she received an at home nurse to help with her care. This was not provided to

everyone, most victims had nothing upon release, especially nowhere to go.

Concern for safety was present upon leaving the hospital. Participants did not have anywhere safe to go. They were scared and fearful of what was going to happen next. Anthony describes:

> Anthony: I didn't necessarily feel safe in Rochester because I wasn't in the right state of mind and I didn't feel safe for myself. Being that I could go for revenge or that he could come for revenge, so I'm more so thinking about my aunt's house.

Some participants had jobs that they needed to return to. Destiny describes the fear she had about returning to her job because it was right near where the violent incident had taken place. She was worried that someone would find her at work and potentially harm her.

> Destiny: Yeah I felt safe in the hotel but I'm just thinking about when I leave here am I really safe because I still have to go back to work and like am I really safe to go back to work and where do I go after this is over with, like what am I going to do now from here. So the first is I need to find a house and I really couldn't find a house for nothing and then DSS sanctioned me. So I'm like oh no everything just feel down.
> […]
> Destiny: So I'm like what if they come up here and happened just to come up here and see me or what if somebody that knew this person and seen this happening just be like oh this is where she works at.

CERV outreach workers stepped in to provide a safe temporary alternative to victims upon hospital release. This alternative was a *cool down period* to reduce the chances of retaliation and revictimization. For Anthony that cool down period took place at his aunt's house in Florida. While for others it was a local hotel stay outside of Rochester. This cool down period was viewed positively by victims. David talks about how his hotel stay was beneficial, giving him time to reflect and think about what had happened.

> David: Yeah because it gave me time to think, think about what I wanted to do and what was going to happen if I did what I wanted to do instead of doing what I knew was right.
> […]
> David: Sometimes once I get in that mode it's kind of hard to get me out of that mode, so it gave me time to think and during the time I was at the hotel Ms. Sabrina was calling and checking up on me, we were kind of having brief conversations about everything, her and my mom.

A cool down period also helped participants feel safe and get everything in order after their victimization. This is described by Ciara.

> Ciara: It was wonderful. I don't think I felt so safe and got so much rest, and the peace of mind in my life. I was able to get stuff put in order and contact people so I can get away from where I was living at.

Maya also shares her experience with the hotel. She was placed in a hotel because her own home was not safe to return to. Feeling safe to Maya meant that no one else could get to her and she made sure of that by checking the doors when she arrived at the hotel. Her CERV contact was also great at staying in touch with her which made her more satisfied with the hotel experience.

> Maya: Yes at the hotel the desk people they was nice, it really was nice, and she wanted to make sure she called me every day and I was good. I felt comfortable and I felt safe, because you just couldn't walk in that hotel, you had to come in the front door and you had to walk past the desk to get anywhere. The side doors was always locked because I checked, and you had to have a little card key to get in the door so I felt safe, I enjoyed my stay.

Hotel stays and *cool down periods* were important to victims and were the only option they had. There were numerous gaps in services upon hospital release with no safe housing options permanent or temporary which led to *instability* for victims. Hotel stays were only temporary short-term options, therefore if victims were not able to get other housing services afterward, this left them with nowhere to go. David describes months after his incident that he had nowhere permanent to live, "I actually stay wherever I could at the moment. I don't have a single stable place to stay. […] So wherever I an lay my head that's where I'm at.". This was also experienced by Destiny who was going house to house like David after she left the hotel. Ciara also experienced *instability* as she describes what happened after her hotel stay.

> Ciara: I went to a friend's house for a couple days because I had a court date and then I went to my sister's and from my sister's house I went to a shelter stayed there for about two days and I ended up finding an apartment.

For some this *instability* only lasted a short while and then they were able to get a permanent

housing option. While others were still experiencing *instability* trying to find a job, an apartment, and even navigating the criminal justice system through parole or probation. CERV participants spoke highly of the program, support, and services they were provided even though life after CERV was not always safe and stable.

Post-Services/Program

Interviews revealed that there is an *inconsistent law enforcement response* following a violence injury. Some victims described situations where investigators met them at the hospital and then followed them throughout the process upon release while others only saw an investigator at the hospital. Perceptions of these interactions also varied. Ciara stated, "Actually I think they treated me better than the hospital staff did.", while others were not satisfied before the interaction even began and denied speaking with the police. This was described by David who stated, "Yeah the investigators came but I told them I didn't want to talk to them." He further states that he has had no contact with them by choice, "I keep telling them, I was basically verbally abusive to the detectives. […] Because I didn't want to talk and they kept coming back trying to get me to talk." This also indicates that there is distrust in law enforcement that exists leading individuals to not interact with them at all. Others have not had contact with police regarding their incident, Alexandra described that the police had not visited her a second time until one month after the incident had taken place. Another victim, Destiny, stated that she has not had contact with the police regarding the incident that took place at all, not even at the hospital. Cameron had deep rooted distrust in the police and, like David, refused to interact with them. Cameron did not feel that talking to the police and telling them what had happened would be beneficial to him because they would not be able to protect him.

Cameron: Because like the way, I know how like RPD is and Rochester, they make it seem

like they're doing their job but then it's like it's always another side like the extra, like what you going to resolve. Are you going to hit me like six months later talking about oh yeah this is this and I could probably be dead or something, you feel me.

Edith further highlights this distrust in law enforcement describing how her son feels regarding the police protecting him in jail after the incident occurred.

> Edith: I mean with him right now he's in a cell by himself and he said because the post traumatic stress he doesn't feel comfortable, he doesn't, like he's scared, he doesn't feel that if someone came in there that shot him that the Police Department would have his back or someone would be able to get to him in enough time where that something else doesn't happen to him.

Violence is a traumatic event not only for those who were victimized but those connected to the victims. Both victims and surrogates revealed the trauma that exposure to violence caused. This trauma led to feelings of *hopelessness*. Victims and surrogates felt that the only way to recover and be safe was to get out the area. If they chose to stay, they felt that revictimization was imminent. This *hopelessness* was about continuing life in Rochester, their safety, and their ability to achieve goals as explained by David.

> David: Actually I feel I'm going to get killed before I reach the age of 25, if you ask me. It's not even like asking me, that's how I know if I stay here I'm going to get killed before I reach 25.
> Interviewer: How old are you now?
> David: I'm only 20 and I've been through shit already that I should have never been through at the age of 20, and half of the shit I went through I went through at a younger age before I even hit 20 and nobody should have to go through that. I feel like I know what I want to do but me being here is holding me back. I already know what I want to do, I want to graduate high school and go to college and get a business associate's degree, but I won't be able to do that if I'm here. Rochester is holding me back, I'm caught up in too much shit here. I'm not going to make it, it's sad to say but I know that.

David's mother Makayla further describes this feeling of hopelessness around living in Rochester and inevitability of violence continuing. David has multiple brothers who have been violence victims, one was a homicide victim shortly before interviewing his mother.

> Makayla: [...] him and his siblings like they just feel like there is nothing else left for them here in Rochester. Like my boys you know, I wouldn't have ever thought I would have lost one of my siblings to the street. It's just that being here is not the same like I don't even

want to be here no more. But like at the same I'm trying to do that, work, stay on top of things cause you know right now we just staying with family we here and there, so with my son that had gotten killed it's like we're living here and there with family we have to prepare for this burial service and this.

[…]

Makayla: […] but my main focus is just trying to save up a little bit of money from work so I've been trying to find a house for me and the boys. I don't want to be in the city even if it's an apartment complex in the suburbs or whatever, I think that's my focus right now I trying to get me and the boys somewhere to stay.

David and Makayla were not the only one who described the need to get out of Rochester. Caleb is

waiting for his license plates to arrive and he states, "If I get my plates I will be gone, I'm going to

be traveling." Maya is worried for herself and her children safety and is trying to move.

Maya: Well I have, well my youngest child he went out to Elmira with his dad and his dad's wife. So I was thinking that I don't know I might want to take my kids and leave and move out there, away from Rochester. I don't know I just don't feel like it's safe here in Rochester, I don't feel that it's safe at all. I'm from the city, I wasn't born but I was raised here […] I was like where is it safe to move, there aint nowhere safe to live. I was looking for something out in Greece like Webster, Irondequoit, Fairport, you know, somewhere on the outskirts cause I still have kids they're used to being around their dad, I want to move because I feel like it's going to be safe because I'll have the kids' dad, just place outside of Rochester, we had people come to the house and don't tell people where you stay at. Places on the outside, I just get to the kids and change themselves.

Edith and her son also feel that leaving Rochester is the only option for safety.

Edith: […] I don't feel like he's safe right now in Rochester, or New York State period at this point where that I want to move him out of here but the trouble is having money to relocate […] But you know, I know for a fact that this is not a safe place for my son and I know that he has a lot of issues around disability and just getting him in a different environment and just try to start a new life would probably be more beneficial for him versus him living in the City of Rochester, don't know who shot him, anything can occur again, this is the second time he's been shot, you know, and it's just not a good place for him.

[…]

Edith: There's always a fear for him of where he can go, and where he can't go and even if he's able to walk to the store and not be in a situation where his mindset is am I going to get shot. In all reality I think like now we've been talking, I've been saying I want to move, I want to move and never before did he want to move out of Rochester and now he's like I want to move, I want to move, I want to get out of here. […] you just don't know who know you and you don't know them, and who may come after him again.

Experiences of trauma ranged from emotional to physical to psychological to behavioral

impacts within the lives of participants. One frequently mentioned trauma symptom that was

mentioned was nightmares. It was not always clear to participants that these experiences were a result of the violence that had occurred. Some of these nightmares were described in detail and appear to be linked to the trauma from current violence and prior experiences. Alexandra describes the intensity of these nightmares that wake her up at night and she knows that they are a result of her victimization.

> Alexandra: It don't make me feel unsafe but it makes wonder like when I have murder dreams I wonder if it's somebody close to me or if something is going to happen. But when I have dreams I wake up out of it because I dream a lot and it makes me sweat and so it wakes me up right out of my dream. So it's like I know where it comes from, it comes from me being shot so I dream more from my incident.

Caleb described in detail what he was experiencing because of his victimization. It seems that his nightmares stem from a variety of experiences that had been occurring at the time of his incident. He also does not know how to manage his symptoms and has not fully linked them to a cause or trigger. Further, he did not feel that seeking help for his experiences was going to work. He thought that if they got worse, then he would seek help.

> Caleb: […] like I'd be having weird dreams. Like I had a dream that I had got shot at my grandma's house one time running downstairs in my back, woke me out of my sleep. I had a dream that I got pulled over and the cop beat me and stuff, stuck their finger in my wound, I'd be having weird dreams like I don't know, it would be just random, it could be anything like I'd be up early in the morning just can't sleep.
> […]
> Caleb: No because I don't know, I have to get out to make it better or if it's just going to get better. I don't know, I feel like it's random, it's not every night, it'll just be every other day or just whenever I just decide to go to sleep, I don't know. I don't even know it just happens and it will be weird, it's some nights I don't even dream I just sleep and then I just have a dream. So I don't even know what would make that better. Honestly I was just trying to take time, every night situation I would go talk to the doctor about that to see what was going on.

Violence is also traumatic for those who are connected to the victims and exposed to violence. This does not only impact them emotionally but also behaviorally as sometimes they cannot do normal activities due to it. Anthony describes the impact that violence has on his children:

> Anthony: That's right in the middle of all the violence. All the violence and I have six kids that live in the house with me and I don't even let them go outside because of things like that.

They don't even know how it feels to play in their own yard because it's just so much, like I don't know.

This is further described by Maya who has five children of her own. These children were in the home with her when she was shot. Since this incident, she has had to find safe housing options and therefore has had to give her children to their fathers and not been able to see them. When asked how this event has impacted her children Maya tells a story about her daughter.

> Maya: […] since the incident she's just decided to cut all of her edges off. She cut her hair off and told me why did you cut your hair, she's with her dad and she's like I just want to be with you mom, but since everything going on she said I just feel funny, I said what do you mean you feel funny, she said everything just feels funny so I just cut my hair. I just said you just woke up in the morning and cut your hair baby. I said so that was the reason you cut your hair, she said I just felt like cutting it. I'm like all the way around like that so you have no edges, like she would cut it a little bit, but she took a razor and cut all of it off all the way around the full circle. I asked her do you want to talk to the therapist and she said yeah.

As participants reflected on the process, the *need for support* appeared to be a driving factor for their satisfaction with project CERV. Just having someone to talk to, care about them, and be there for them was instrumental to recovery. Some victims even highlighted that if it were not for CERV they would not have had anyone to go to for support. David states "I knew I wouldn't have had nobody to turn to.". Anthony mentions how important it was to have someone who cared.

> Anthony: That was actually a good experience. I never had no one, still to this day, I've never had no one but my own parents to actually call and reach out and check up on me to ask how I'm doing. So for her to remember my name and remember who I am and to call out and check up on me that is wonderful.

Destiny felt strongly about the support she received that she has recommended CERV to others. CERV was also able to assist her in leaving the gang she was a part of, without the support she received she would still be a part of that group.

> Destiny: Like friends like I used to, like my friends that was in the same situation like me that just go around and do anything just for attention cause we didn't have none. These people will show you attention where you don't have to go do that stuff, you know. People that just call and check on you, that's what we are needing. So I tell my friends just use this number or just go ahead and stop in because they just might be there. They'll be there just need somebody to talk to because they will talk to you.

Ciara described how heightened emotions were reduced after connecting with project CERV.

> Ciara: It felt like I connected with you all, I felt hopeless, scared, didn't really want to live because of everything I was going through, then when I met you all I felt like somebody actually cared, somebody is actually going to help me.

Edith directed her son's care and safety planning. She found that project CERV helped her navigate all the different systems and individuals she encountered. She was grateful to have the support in these situations.

> Edith: Because there's some consolation in there when you have no one to talk with you know you were like an advocate for him as him being a victim. You were the one that me being stressed out not knowing which way to turn and where to go, you know, being able to talk to you and you having the resources that you had to offer and trying to help me navigate through things by it really being my first time experience with this. Parents and family members need someone to support them through the process otherwise you're not getting it from the Police Department, you're not really getting it from the hospitals. The social worker at the hospital really had nothing to offer me other than sending him to a homeless shelter. You being able to say that this is a matter that's urgent and he's not safe that helped for other people to kind of think outside the box and be able to make more opportunity for him to be able to get out of that environment which may cause more injuries for him long term.
> […]Where when I came to a dead end or a tunnel where that these people are supposed to be part of his circle, however, they're not showing me any support as the mom and not showing him any support as the victim and looking at the situation like it's not urgent, then that person from CERV intervening and being able to kind of reach out to these people as a professional person, that helped, it filled in the gap. Where for me I had to wait a week or two to get answers where she's able to intervene and get these answers.

Something as simple as having support and someone to care about victims after their injury was crucial to their recovery and healing. It also empowered them. Maya felt that the people involved in project CERV were instrumental to where she was. She states, "They was very helpful and it motivated me cause I felt like the world had came to an end." Destiny also describes the empowerment that she felt after engaging in CERV.

> Destiny: More confident in myself, more confident that I'm going to do better, showed me that people is really here to help us people not just here to do something to get rewarded for them helping you, they really want to help you. So it just made me feel better, it gave me like a little push to do better, to do what I was already doing.

Although some participants felt empowered and motivated over time, for others they felt *exhaustion*. Life after victimization seemed to be an upward battle. From the lack of services to having nowhere to go to losing a job and having to find another one to having to pick up and restart an entire life. This *exhaustion* occurred post-release immediately after the hospital treatment and spanned well after the program or services that victims received. David states "I don't know, I'm emotionally frustrated, I may give up, may break down, I'm just kind of done with this shit." Destiny also felt like to David after struggling to find a stable place to stay.

> Destiny: Depressed, just depressed, just ready to give up, just tired I guess, just really, really tired.
> […]
> Destiny: Just give up, just say forget it, I don't know what to do anymore, I don't know. Just was tired. I didn't know what to do, like literally did not know what to do, all I did was go to work every day cause I did not know what to do and work was the only think to get it off my mind so I just went to work every day. Work, work, work. Then work got overwhelming, it still is overwhelming.

Makayla further states that she was burnt out yet grateful for the help and support she received from CERV. She explains further:

> Makayla: I'm not doing, I mean you know I'm just taking everything day by day and just taking it with a grain of salt. Like I honestly like (inaudible) I haven't had that time to just like grieve my son's death like because I know I've got so much stuff I need to do. So I like trying to get back into the swing of things so I'm not like I'm tired, I'm drained, I don't sleep much. Of course you know I just ask God to give me the strength to keep pushing because I got stuff I need to do. I need a house, I've got to get stuff for me and my kids, and for my family, so it's like tiring. But mentally and physically I'm drained, it's taking a toll but I've got to do what I need to do like if I don't do it who else going to do it.

Although there were positive moments with these participants, life after victimization was an upward battle for them. Emotions were heightened, the treatment they received by institutions especially the hospital left them feeling uncared for, unsupported, and frankly scared for their lives. Upon hospital release, victims had nowhere to go with fear of retaliation, still no one was there to deal with the trauma that they had experienced. The hospital system is the first point of

contact for victims, yet most of them left those encounters unsatisfied, confused, and scared. Victimization impacted the victims as well as their surrogates emotionally and physically. Some of the victims are still fearing their safety and working to find a stable safe place to live. Interview findings highlight the complexity of their situations and how lack of trauma management by one institution leads to worse outcomes overall.

Discussion

The goal of customer journey mapping is to understand the gaps in services during a customer experience. For violence victims and their surrogates, there were numerous gaps that were identified surrounding hospital treatment, law enforcement, and post-release services. There were a range of responses regarding satisfaction with their experience. Satisfaction tended to be linked with feeling heard, supported, and cared for. This lacked with the hospital staff, service providers, and law enforcement. Journeys varied including the number of and which touchpoints and channels they had, but the underlying finding was that at each of these points there were systems that did not provide for them. Although journeys were unique, experiences were similar. Victims are in a vulnerable state at the hospital, feeling scared, angry, sometimes even alone, and the hospital staff were not providing adequate care, compassion, or empathy for victims. Some of this stems from not treating a traumatic event as traumatic.

Findings from these victims were similar to what Opara et al. (2020) found. One of the key similarities was this drive to leave the area following violence. Feeling as if the only way to move forward was to get out of the current unsafe location completely was mentioned by half of the cases included in this study. Safety was also a large concern mentioned by every participant. The need to feel safe and uncertainty of retaliation or further victimization influenced the behaviors of and mental status of participants. Retaliation was a huge concern both contemplating getting

revenge and worrying about someone coming back to harm them again. This is consistent with existing research around violence victimization (Anderson, 1999; Klofas et al., 2020). The concern was not only short term at the hospital but continued beyond engagement with CERV. One participant even mentioned that the conflicts do not just disappear. This fear around further violence led victims to want to leave the area some even stating openly that they felt they were going to die. CERV assisted in efforts to delay this victimization or prevent it. CERV provided cool down period in the form of temporary hotel stays. Victims found this to be beneficial to their healing and allowed them time to think. Other services were not available when these temporary options ended leaving victims unstable, exhausted, and hopeless.

Distrust in law enforcement was also consistent with literature around the nature of violence (Anderson, 1999; Rich & Grey, 2005). This distrust exists in communities already but is heightened when there are inconsistent responses to the violence that is occurring. When victims were first injured, none of them called 911 themselves. At the hospital, participants did not trust that law enforcement would be able to protect them or solve the case so they either chose not to talk to them at all or accepted the fact that they would only speak with them once. The lack of follow up from law enforcement led victims to believe that no arrest had been made and police did not care about the incident that occurred. This did not assist with the fear that victims and surrogates had. If violence was being managed and police were trusted to assist them, leaving may not be perceived as the only option to be safe. Further, the mentality of handling the problem themselves instead of turning to the police was consistent with Rich and Grey (2005).

Interviews also revealed community trauma where violence not only impacted victims but also surrogates including parents, siblings, and children. There were no mechanisms in place to manage the trauma that they felt. Most of the systems they interacted with only exacerbated their trauma, retraumatized them, and made life more challenging. Each of the surrogates interviewed

were either mothers or played a motherly role to the victims. The trauma and pain that the victims faced directly impacted surrogates and they too revealed symptoms of trauma such as a daughter cutting her hair after her mother was shot. CERV provided temporary support to victims and surrogates to assist with trauma but there were no long-term connections to further assist them. Consistent with the literature around exposure to violence, participants experienced emotional trauma through exhaustion, depression, anxiety, and psychological trauma, including experiencing nightmares, hypervigilance, and post-traumatic stress disorder.

Overall, victims and surrogates spoke highly of the CERV program. Most of this centered around having someone to support them and help them in the aftermath of a crises. Support was one of the top reasons for satisfaction. Compassion, empathy, and support lacked from these main institutions but from the participant perspective was provided by CERV staff. Even if after their interaction they were still struggling, they still found CERV to be instrumental to their healing and life changes. This indicated that there is a complete lack of support and care in the community for these individuals. The hospital did not act as if they cared for them, mistreating their injuries, releasing them without anywhere to go, not concerned for their trauma. Just having someone there to guide them, empower them, and assist them was very meaningful.

Limitations

This study was not without limitations. The first limitation was the difficulty with identifying victims for interviews. Violence victims are hard-to-reach and without identification at the hospital, recruitment became challenging. Even when identification for interviews expanded beyond the hospital, community partners struggled to identify victims. It may be that victims were genuinely not interested interviews, or that our partners were not actually approaching individuals. Victims are at the hospital for a very short time making it difficult to identify and engage them to

ensure long-term connections and interview participation one month later. Therefore, this analysis had a small sample of interviews and did not allow for a comparison group of non-CERV victims.

Another limitation with a hospital-based recruitment is the 30-day gap between hospital release and interview. This was to ensure that there was time to reflect on the incident, decrease the risk of retraumatization, and that there was a post-release, post-services stage. Some victims were interviewed more than 30 days after the incident, and it was clear that they did not remember certain parts of the journey. This may have been because of the time gap or their trauma. This gap posed huge challenges for recruiting interview participants as well. Once victims leave the hospital, they were hard to reach again. Some of them do not provide the hospital with reliable phone numbers, some are harder to engage with, and some of them are unknown to our partners and therefore we had no connection to reach them.

Customer journey mapping also has limitations. The methodology has been traditionally conducted in the marketing field and is still new in social sciences (Crosier & Handford, 2012; Rosenbaum et al., 2017). However, across the literature, this method appears flexible and there is no single method template. The elements lack concrete definitions and guidelines to help conduct the method. For this study, existing literature was examined, and criteria were chosen based on the goal of identifying gaps in care for violence victims. Therefore, thoughts, emotions, and experiences were defined based on the understanding of these items in other studies. The flexibility of this methodology especially in the visualization of journeys allows for creativity and expansion across disciplines.

Conclusion

This paper presents findings from 12 interviews with violence victims and surrogates. Interviews revealed that violence is a traumatic event that not only impacts victims but everyone

surrounding them. The aftermath of a violent injury not only effects people short-term but even has lasting long-term impacts. Victims experienced various gaps in services after their victimization which only complicated their healing and recovery. These gaps included mistreatment by the hospital, dissatisfaction around hospital care, inconsistent law enforcement responses, and exclusion from housing options. Life after victimization was an upward battle for victims. Through wound healing, navigating different systems, feeling safe, and avoiding retaliation, victims experienced trauma that only intensified after their injury. Victims were immensely grateful to have a program like CERV to support and care for their needs. This speaks to a need for more systems and institutions to manage the trauma that victims face. Interviews highlight that managing someone's trauma does not mean a formal, therapeutic institution, it can simply be having someone to care, support, and help them. This is instrumental to a positive outcome and a positive perception of the experience with various institutions. Those systems where victims felt satisfied stemmed from feeling that they were cared about.

These findings lead to a few recommendations for improved care of violence victims and better outcomes overall. Life after victimization should not be an upward battle where victims face numerous barriers. First, everyone who engages with or works with violence victims should be trained in Solution Focused Trauma Informed Care (SFTIC). This training provides techniques for assisting individuals without retraumatizing them. These findings reveal a lack of consideration for the trauma that is being experienced by victims and in turn, the trauma these victims and families face is exacerbated. This training should assist with reducing the negative outcomes around the lack of care and compassion for victims.

Second, hospital staff should consider more than the medical trauma that enters the emergency department. It can be challenging for hospital staff to address the physical injury and the psychological and emotional trauma that is occurring simultaneously. However, the lack of

consideration beyond medical needs of victims led to dissatisfaction. Third, there should be mandatory safety plans in place for victims before hospital release. Life after they are released from the hospital does not get any easier. Many of the victims experienced a concern for safety and had nowhere to go. Victims should not be released from the hospital without a safety plan in place which would not only improve safety but decrease the immediate risk for revictimization. These recommendations may include having outreach workers staffed at the hospital, or hospital social workers assigned to patients, or patient advocates who can assist with safety plans. Some type of mandatory hand off should be in place to increase safety and decrease fear post release.

Fourth, there should be a consistent law enforcement response. Law enforcement should engage with victims equally throughout the process and should not only visit at the hospital, but they should also follow-up post-hospital release. Only visiting victims in the immediate aftermath of trauma at the hospital will not increase the likelihood that someone will share information. It is important that law enforcement follows up with victims after the hospital, consistently, before labeling them as uncooperative. Lastly, emergency community housing options for violence victims should be available. There are currently no emergency safe housing options for violence victims. However, these services are available for other populations such as domestic violence. Housing options to reduce revictimization and retaliation for violence victims should be in place.

Future research should continue interviews with violence victims to allow for a larger sample size and for more detailed findings regarding the violence victim experience. It would allow for a comparison group of those who receive services and those who do not and the outcomes of these individuals in relation to violence. Lastly, future research should apply what is known about violence in Rochester and community trauma to understand the surrogate impact on a larger scale. Specifically, how institutions can assist surrogates and utilize them to support victims and reduce future violence.

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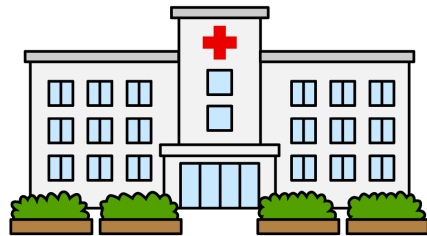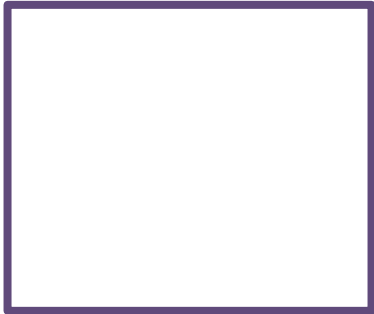
The Victim Journey (Interviewer Edition)

1. Did you/Anyone call 911
2. How did you get to the hospital?
3. Been to RGH Before for assault/prior knowledge of hospital?
4. What were you feeling during all of this? (scared, lonely, sad, anxious)?

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1. Tell us about your hospital stay.
2. Were your concerns met by the hospital staff?
3. How was your hospital experience?
4. Did the police visit you while in the hospital? (How did it go?
5. Who told you about Pathways/CERV
6. Why did you agree to participate?
7. What were you feeling during all of this? (scared, lonely, sad, anxious)?
8. Would you recommend RGH to another victim of violence?

1. What happened after you were released?
2. Do you recall who you were communicating with/working with directly?
3. Was there something that you needed that you did not receive assistance with?
4. Did the services provided to you help?
5. Did the assistance presented to you prevent the violence from continuing?
6. Were there any barriers that you faced while receiving assistance?
7. Was there any continuation of violence your release?
8. Would you recommend a program like CERV to another victim of violence?

1. How are you doing now?
2. Do you feel safe?
3. Is the dispute over?
4. Did this program help end the dispute?

The Non-CERV Victim Journey (Interviewer Edition)

5. Did you/Anyone call 911?
6. How did you get to the hospital?
7. Which hospital did you go to?
8. Been to this hospital before for assault/prior knowledge of hospital?
9. What were you feeling during all of this? (scared, lonely, sad, anxious)?

9. Tell us about your hospital stay.
10. Were your concerns met by the hospital staff?
11. How was your hospital experience?
12. Did the police visit you while in the hospital? (How did it go?)
13. Did anyone tell you about Pathways/CERV?
14. What were you feeling during all of this? (scared, lonely, sad, anxious)?
15. Would you recommend this hospital to another victim of violence?

9. What happened after you were released? (Did you return home? Was it safe to go home? Were you offered somewhere else to stay for a few days? Did you have the resources to do this?)
10. Did the police visit you after you were released from the hospital?
11. Did you receive any services upon release? If so, did the assistance presented to you prevent the violence from continuing?
12. Was there something that you needed that wasn't provided to you?
13. Were there any barriers that you faced while receiving assistance?
14. What elements of CERV would have been helpful (e.g., facilitating safe housing, coming up with an action plan, dispute mediation, wraparound funds, supporting surrogates)?

5. Was there any continuation of violence upon your release?
6. Were there any services you received that were helpful? What were they? What made them helpful? What was most helpful?
7. How are you doing now?
8. Do you feel safe?
9. Is the dispute over?

The Surrogate Journey (Interviewer Edition)\

10. What is the relationship between you and the victim?
11. How were you notified of the incident? What were your initial feelings?
12. Are you aware of anyone calling 911?
13. How did they get to the hospital?
14. Been to RGH Before for assault/prior knowledge of hospital?
15. What were you feeling during all of this? (scared, lonely, sad, anxious)?

16. Tell us about your experience with the hospital.
17. When you arrived at the hospital on behalf of the victim what did you encounter/experience?
18. Were your concerns met by the hospital staff?
19. How were you treated as the ___ of the victim? Were you allowed to visit?
20. Did the police talk with you while the victim was in the hospital? (How did it go?)
21. Who told you about Pathways/CERV?
22. What were you feeling during all of this? (scared, lonely, sad, anxious)?
23. Would you recommend RGH to another victim of violence?

15. What happened after victim was released?
16. Were you involved in the caretaking of the victim? How was that for you?
17. Did you receive any direct support from Pathways/CERV? Who were you in contact with?
18. Was there something that you needed that you did not receive assistance with?
19. Did the services provided to you and ___help?
20. Were there any barriers to receiving assistance?
21. Was there any continuation of violence after the victim was released?
22. Would you recommend a program like CERV to another victim of violence?
23. How did your ___'s involvement with this program make you feel? (relieved, worried, happy, etc.)

10. How are you doing now? How is the victim doing now?
11. Do you feel safe?
12. Is the dispute over?
13. Did this program help end the dispute?