6-2022

The Relationship between Adolescent Exposure to Community Violence, Depression, and Resilience

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CERTIFICATE OF APPROVAL

Clinical Research Project Title

The Relationship between Adolescent Exposure to Community Violence, Depression,

This is to certify that the Clinical Research Project of

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has been approved by the CRP
Committee on

May 19, 2022

as satisfactory for the CRP requirement
for the Doctorate of Psychology degree
with a major in Clinical Psychology

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The Relationship between Adolescent Exposure to Community Violence, Depression, and Resilience

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A Clinical Research Project submitted to the faculty of the Illinois School of Professional Psychology at National Louis University in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology

Chicago, Illinois

May 2022

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Abstract

The present study experimentally investigated the development of depressive symptoms in adolescents who have been exposed to community violence. Participants (N=334) were asked to take a survey of 81 questions addressing one's exposure to neighborhood violence, resilience, and depressive symptoms. Participants exposed to community violence reported more depressive symptoms in every category except Ineffectiveness. Participants who were exposed to community violence also reported higher resilience levels. Given the results, more research is needed to understand the specific factors of resilience that may prevent adolescents exposed to community violence from developing depressive symptoms.

Keywords: exposure to community violence, resilience, depressive symptoms, adolescents

Chapter 1

Introduction

Community violence is an ongoing and growing problem within the United States. Community violence is often associated with individuals who belong to economically underprivileged families and racial/ethnic minority populations. This type of violence can involve violence enacted on or witnessed by an individual(s) within their neighborhood (Lynch, 2003; Poquiz & Fite, 2018; Slopen et al., 2012; Heleniak et al., 2017). Exposure to community violence has been defined as violence in a local neighborhood that typically involves crime and weapons (Collins et al., 2013). According to Dubé et al. (2018), research suggests that experiencing or being exposed to violence significantly predicts psychological distress such as depressive symptoms, anger, and PTSD symptoms.

Due to the growing violence, it is crucial to consider the impact of this community violence on mental health. Areas with high crime rates have an increased susceptibility to community violence exposure (Cooley-Quille et al., 2001; Voisin et al., 2011). Furthermore, residents exposed to community violence have often compared the violence within their neighborhoods to war zones with no imaginable end (Fowler et al., 2009).

Additionally, it has been found that the effects of community violence vary by the proximity of the witness or victim to the violent event (Fowler et al., 2009). Adverse mental health outcomes have been linked to exposure to community violence. Several adolescents who live in inner cities are likely to witness a homicide before reaching early adulthood (Zimmerman & Farrell, 2013). Several studies have also found a relationship between adolescent exposure to community violence and short-term and long-term symptoms of PTSD, depression, anxiety, and other psychological stress and complex trauma (Mazza & Reynolds, 1999; Lynch, 2003;

Rosenthal, 2000; Mrug & Windle, 2010). Moreover, academic, behavioral, and social relationship difficulties, chronic hyperarousal, overall sense of insecurity, emotional dysregulation, lower levels of problem-solving, self-rejection, suppression of sadness and anxiety or even desensitization have all been linked to exposure to community violence (Chen et al., 2014; Heleniak et al., 2017; Lynch, 2003; McGee, 2014). With time, community violence exposure has been linked to defiance and aggressiveness (Lynch, 2003; Fowler et al., 2009; Kennedy & Ceballo, 2016; McGee, 2014).

Research suggests higher risks for adolescents exposed to community violence to develop conduct disorder and initiate drug and substance use (Cerdá, Tracy, Sánchez, & Galea, 2011; Lynch, 2003). African American adolescents, specifically, are more likely to engage in sexual risk behaviors when exposed to community violence (Voisin, Hotton, & Neilands, 2013). Furthermore, exposure to community violence can affect the physical health of adolescents, including an elevated heart rate, a change in cortisol production, asthma morbidity, and a slower pubertal development (Chen et al., 2014; Zimmerman & Farrell, 2013).

Research has shown long-term impacts of exposure to community violence that lasts in adulthood; adults exposed to violence during adolescence are frequently linked to delinquency, unemployment, and homelessness (Chen et al., 2014; McGee, 2014; Poquiz & Fite, 2018). However, resiliency appears to be a protective factor limiting the harmful outcomes of exposure to community violence (Jain & Cohen, 2013).

This study would be pivotal and instrumental in the existing research because it would allow others to further understand the role of resilience in how adolescents exposed to community violence react or develop such mental health symptoms. This research is needed to know how to analyze and treat adolescents who have been exposed to such violence.

The current study will examine the relationship between adolescents' exposure to community violence, the development of depressive symptoms, and their resilience levels that play a role in the outcomes of exposure to community violence. It is hypothesized that (1) Adolescents who are living in neighborhoods with high levels of community violence who are exposed to community violence are more likely to develop depressive symptoms, (2) Inner-city adolescents who have been exposed to community violence but do not present depressive symptoms have higher resilience levels. This study will consider both forms of community violence: indirect and direct.

Chapter 2

Literature Review

Community Violence

Of all forms of violence, one can experience, exposure to community violence has the highest probability of occurring (Slopen et al., 2012). Although this type of violence can occur across the United States, in 2008, Illinois had the highest rate of violent crimes than any other state. Furthermore, it was discovered that boys and girls are exposed to and cope with community violence differently (Voisin et al., 2011).

According to Overstreet (2000), community violence can frequently be categorized in two forms: direct and indirect. *Direct violence* is the violence that is directly inflicted on a person. People who have experienced this type of violence would be identified as *victims* (Overstreet, 2000). *Indirect violence* is the violence that another person witnesses. This indirect violence can occur in knowing someone who has been a direct victim of community violence or watching a violent act occur in the community. Some examples of community violence are being a witness or victim of shootings, stabbings, and physical fights (Overstreet, 2000). Indirect violence can also include witnessing an event, being threatened, or hearing about the event (Fowler et al., 2009). Forms of community violence may also consist of but are not limited to gang violence, gang initiations, or other attacks made by gang members. All forms of community violence can negatively impact an individual's mental health; exposure to violence can create a sense of endangerment within their community and distrust in other groups of people (Chen et al., 2014).

Adolescents' Exposure to Community Violence

Exposure to community violence negatively impacts all individuals, but adolescents are most susceptible to the effects of community violence as this is a significant time during

development (Gaylord-Harden, So, Bai, & Tolan, 2017). Literature has reported sex differences in how community violence is experienced. Young boys are more likely to be victims of this direct violence than their female counterparts (McGee, 2014). The research indicated that both genders share the same distress with direct violence. Girls, however, are more likely to feel distressed by indirect violence exposure (Voisin et al., 2011). Girls have also been seen to have higher anxiety levels due to violence within their communities (Reid-Quiñones, Kliewer, Shields, Goodman, Ray, & Wheat, 2011).

Additionally, African American adolescent girls are more likely to report dysfunctional or maladaptive emotional regulation skills due to exposure to community violence. Emotional regulation skills can be described as skills utilized to cope with, influence, and modify one's experiences (Sun et al., 2020). Having good emotional regulation skills helps with being able to develop resilience in adolescents (Sun et al., 2020). Adolescents and children exposed to direct or indirect violence are at higher risk of developing trauma symptomology. This trauma symptomology can take the form of an increase in fear, depression, and anxiety (Cooley-Quille et al., 2001). There is a positive relationship between high exposure to community violence and fear, anxiety, and internalizing behavior (Cooley-Quille et al., 2001). In addition, separation anxiety has been found to occur in adolescents who have been exposed to such violence (Cooley-Quille et al., 2001).

Internalizing and externalizing behaviors can be effects of exposure to community violence in children and adolescents (Cooley-Quille et al., 2001; So et al., 2015). Internalizing behaviors can consist of depressive and anxiety symptoms, such as excessive worry and social isolation (Cooley-Quille et al., 2001; DaViera & Roy, 2019). Externalizing behaviors are described as aggression, delinquency, and antisocial behavior (DaViera & Roy, 2019). Adolescent exposure to

community violence is strongly associated with aggressive behaviors (So et al., 2015). This aggressive behavior is suggested to worsen and develop into delinquent behaviors over time if left unaddressed (So et al., 2015). Many of these aggressive behaviors can be described as physically fighting, bullying, cruelty towards other people and animals, and temper tantrums (So et al., 2015). Delinquent behaviors are lying, truancy, vandalism, and stealing (So et al., 2015). In a study conducted by Burnside & Gaylord-Harden, (2018), it was revealed that low aspirations and hopelessness for one's future predicted exposure to violence one year later due to involvement in delinquent behavior (Burnside & Gaylord-Harden, 2018).

Furthermore, a study conducted by White et al. (1998) found that young girls who reported more exposure to violence appeared to show a more significant amount of concentration anxiety or difficulty concentrating than boys. Throughout this study, it was also found that being exposed to community violence regularly is not out of the ordinary either. This research also found protective factors for adolescents. Family support was identified as a protective factor for anxiety (White et al., 1998). This study indicated that some adolescents exposed to community violence are likely to experience anxiety symptoms, emotional dysregulation, and additional difficulties (Heleniak et al., 2017; White et al., 1998).

When exposed to violence, there is a higher risk of girls developing emotional problems (Kersten et al., 2017; Bordin et al., 2021). However, males have a higher probability of presenting with conduct problems after witnessing community violence (Kersten et al., 2017; Bordin et al., 2021). Furthermore, in a study by Kersten et al. (2017), results indicated a positive relationship between exposure to community violence and children and adolescents in both the control and study groups of developing conduct problems.

Additionally, children and adolescents exposed to community violence can also develop school functioning problems. School functioning problems in this study were described as attention and concentration difficulties, cognitive impairment, stress-related intrusive thoughts, fear of going to school, low academic motivation, and low perception of safety at school (Koposov et al., 2021). For instance, in a study that included Belgium, Russia, and the United States conducted by Koposov et al. (2021), results suggested that youth who experienced any form of community violence exposure (indirect or direct) demonstrated school functioning problems.

As of 2017, exposure to community violence was being considered by the World Health Organization (WHO) and Centers for Disease Control and Prevention (CDC) to be a new category in the ACEs (Adverse Childhood Experiences questionnaire). Due to a testing process, exposure to community violence was incorporated into a study, and it was found that there was a positive relationship between exposure to community violence and the mental health of children and adolescents. Research has discovered that children and adolescents have reported significant exposure to community violence, and it only seems to be increasing among school-age children (Lee et al., 2017).

A meta-analysis conducted by Fowler et al. (2009) revealed that exposure to community violence affected individuals most strongly with Post-Traumatic Stress Disorder (PTSD) and externalizing problems. Externalizing problems can be defined as aggression, deviant or violent behavior, and other measures of acting out (Fowler et al., 2009; Lynch, 2003). Overall, those who were victims of direct community violence were more likely to internalize their symptoms than those who only witnessed the violence (Fowler et al., 2009; Lynch, 2003). Those who were direct victims of violence were more likely to have psychological symptoms or problems such as

helplessness, high levels of traumatic stress, and the development of substance abuse (Fowler et al., 2009; Lynch, 2003).

A study by Quinn et al. (2017) found that the trauma of exposure to violence or harm can lead adolescents to want to join gangs to rid themselves of the anxiety.

Some adolescents reported that they might do this to feel protected from that violence and a sense of affiliation. The adolescents of this study revealed that they would rather deal with the violence while in a gang than deal with it on their own, outside of a gang. Many adolescents who are witnesses or victims of community violence are also exposed to other risk factors, such as drugs and poverty (Quinn et al., 2017). The coping strategies for dealing with chronic community violence and acute trauma differ. Being exposed to consistent community violence can lead to excessive fear and worry that frequently lead adolescents to feel that they have no choice but to create new ways to feel safe (Rasmussen et al., 2004).

Depression and Resilience

Depression is a mental health diagnosis that has been researched heavily for adolescence and young adulthood. According to the American Psychiatric Association (2013), depression is defined as a mood disorder. The individual experiencing depression would have to meet five or more symptoms within two weeks. Depressive symptoms include depressed mood nearly every day, markedly diminished interest or pleasure in all activities every day, significant weight loss or weight gain (not due to a diet), or decreased or increased appetite and at least one of the symptoms needs to be a depressed mood or loss of interest or pleasure. Furthermore, a slowing down of thought or physical movement, fatigue or loss of energy nearly every day, feelings of worthlessness or excessive, inappropriate guilt almost every day, diminished ability to think or concentrate or indecisiveness nearly every day, recurrent thoughts of death, suicidal ideation

without a specific plan, or a suicide attempt or a detailed plan for committing suicide (American Psychiatric Association, 2013).

The onset of anxiety and depressive disorders are connected to early adolescence, and the highest rates are from ages 15 to 18 (Heleniak et al., 2017). Furthermore, suicide which is often associated with depression is the third leading cause of death in adolescents ages 15-19 (Miliauskas et al., 2021). This information highlights the importance of understanding where depressive symptoms can stem from. Research has found a decrease in trust and faith in the legal system when adolescents have experienced community violence (Chen et al., 2014). Viewing the world as a hostile place and viewing aggression and behaviors that follow, such as violence, has been linked to exposure to community violence (So et al., 2015). Research has also found that community violence may be challenging for adolescents to participate in daily activities in their communities because they may fear their safety (Chen et al., 2014).

In research conducted to examine depressive symptomology among African American children and adolescents ages 10-18, adolescents were more likely to develop depressive symptoms when living in dangerous and threatening environments (Fitzpatrick et al., 2005). Moreover, it was found that social capital, such as social and personal resources for these participants to depend on, positively affected whether these adolescents presented with depressive symptoms (Fitzpatrick et al., 2005).

Ethnic minorities are more likely to live in a low socioeconomic community, making them more likely to be exposed to community violence (Poquiz & Fite, 2018). Community violence is more likely to impact adolescent minorities within inner cities, often due to ethnic minorities being classified as having low socioeconomic status and populating areas with higher crime rates (Cooley-Quille et al., 2001). Due to African American and Latino adolescents being more likely

to be located in urban settings, it has also been found that these individuals are far more likely to be exposed to community violence (Alers-Rojas et al., 2020; Bennett & Joe, 2015). They are also more at risk for related mental health consequences due to exposure to violence (Alers-Rojas et al., 2020; Bennett & Joe, 2015). Prior research suggests exposure to community violence to depressive symptoms and substance abuse (Bennett & Joe, 2015). Depressive symptoms and substance abuse have been found to have the strongest relationship with suicidality (Bennett & Joe, 2015). There is limited research on community violence and suicidality. However, that does not limit the possibility of suicidality resulting from exposure to community violence (Bennett & Joe, 2015).

According to Kennedy and Ceballo (2016), adolescents exposed to community violence are likely to become emotionally desensitized and "emotionally numb." Community violence becomes an expected norm, and adolescents do not have a hopeful and optimistic perspective of the world (Lynch, 2003; Kennedy & Ceballo, 2016). Adolescents may feel hopeless with their experience of community violence and view the world in a negative light or pessimistically. This way of thinking can lead adolescents to develop risky behaviors. Desensitization is a way of masking feelings of sadness, worthlessness, and hopelessness. Desensitization is often thought to lead those exposed to violence to commit violent acts to cope or survive their distress (Gaylord-Harden et al., 2017; Kennedy & Ceballo, 2016; Lynch, 2003).

In addition to the consistent developmental changes experienced in adolescence, community violence can make it more difficult due to the sensitive nature of the developmental period. Due to this crucial developmental period, it is easy for adolescents to react aggressively when feeling threatened by community violence. It was also found that African American

adolescents experienced community violence more than once in their upbringing (Gaylord-Harden et al., 2017).

Exposure to violence within the community was a factor in increased aggression and depression among African American and Latino adolescents (Gorman–Smith & Tolan, 1998; Alers-Rojas et al., 2020). In a study conducted by Gorman-Smith & Tolan (1998), it was suggested that this may have been due to the relationship that many of these adolescents held with their families. This finding implied that aggression and depression are likely in minority adolescents exposed to community violence (Gorman–Smith & Tolan, 1998; Alers-Rojas et al., 2020). However, only boys participated in this study; there was no information about young girls. It is pivotal to know the effect of exposure to community violence on a general population of adolescents (Gorman–Smith & Tolan, 1998). According to Cooley et al. (2019), adolescents living with depression tend to blame themselves for the adverse events that have occurred to them. Girls, specifically, tend to turn to a more ineffective rumination coping strategy. Boys typically turn to aggression to deal with the depression and irritability that comes with it (Cooley et al., 2019).

While examining the differences between exposure to direct and indirect violence and the relationship between health problems and mental health services used, it was indicated that participants exposed to direct violence as adolescents were more likely to experience depression as adults (Chen et al., 2017). Depressive symptoms increase the risk of developing poor friendships and relationships, low academic functioning, substance use, alcohol use, and suicide. Positive parent-child communication among individuals living in urban, high-risk areas is a protective factor in reducing depressive symptoms in children and adolescents (Chen et al., 2014; Eisman et al., 2015).

While examining multiple settings and the experiences of violence that may be linked to Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD), it was discovered that indirect violence or hearing news about violence could increase the risk of mental health issues (Slopen et al., 2012). Researchers have found that the development of MDD led by community violence is higher than experiencing any other kind of violence, such as home or school violence (Slopen et al., 2012). The risk of developing GAD is much higher for those who have experienced community or neighborhood violence than any other type (Slopen et al., 2012). Therefore, exposure to violence in children and adolescents increases the risk for MDD and GAD (Slopen et al., 2012).

Resiliency and Community Violence

Literature on resilience and exposure to community violence focuses on coping strategies and protective factors that may assist adolescents who have been exposed to community violence (Voisin & Berringer, 2014). Several studies identify coping strategies linked to a "healthy outcome" and a negative outcome to coping with exposure to community violence. It has been suggested that adolescents are not the only individuals who could be affected by community violence. Parents and older adults who care for adolescents may also be affected, which calls for an even more difficult time coping with such violence (Voisin & Berringer, 2014). Borre and Kliewer (2014) found that parents are more likely to feel unsafe in impoverished neighborhoods with little to no resources and limited public services, and where there are also high violence and crime rates. Living in these neighborhoods often adds parental strain on wanting to provide a safer upbringing for their children. Parental exposure to community violence and lack of positive or adaptive coping skills can cause many parents to develop depression, hostility, or anxiety (Borre

& Kliewer, 2014). Due to these severe psychological effects on parents, less awareness of their child's whereabouts may occur (Borre & Kliewer, 2014).

According to Aisenberg & Herrenkohl (2008), single-parent families are more at risk of experiencing community violence. Those who have poor living and housing conditions, lack of resources, and types of support are also more likely to experience this type of violence. Other structural characteristics that may also qualify as risk factors are the frequency of substance use by the caregiver and the accessibility of firearms to adolescents. Some important outcomes of community violence mentioned are the lack of ability to move forward and succeed. Furthermore, the experience of living in a neighborhood with high violence may also put adolescents at risk of not being able to establish positive relationships with others around them (Aisenberg & Herrenkohl, 2008).

Family relationships have been found to play both positive and negative influences on the role of exposure to community violence (Chen et al., 2014). However, research suggests that positive and close relationships with family members, especially parent-child relationships, and sufficient parent monitoring have helped minimize the risk of youth being involved in or witnessing community violence. Although parent or caregiver-child relationships can reduce the risk, they can also do more harm than good if these parents or caregivers have become distrustful of the environment or community they reside (Chen et al., 2014). This can cause parents or caregivers to influence or discourage their children from becoming involved in their community to protect them from the violence (Chen et al., 2014).

Reid-Quiñones et al. (2011) indicated that the primary emotional response was anger, sadness, and fear, while the central coping strategies were primary engagement and support-seeking. They suggested that direct engagement was viewed as dealing with whoever started the

problem or seeking validation from others related to threats to oneself. The way an adolescent reacts to being exposed to violence can result in detrimental mental health outcomes (Reid-Quiñones et al., 2011).

In addition, Jain and Cohen (2013) suggested that adolescents who had witnessed community violence had about a 50% chance of having age-appropriate behavioral functioning than those who were victims of such violence. The victims of community violence had approximately a 28% chance of having the same type of behavioral issues as those who only witnessed the violence. Furthermore, adolescents with stronger family relationships and peer support had higher chances of having typical behavioral problems. It also appeared that strong peer support increased healthier behavioral functioning and decreased aggression and delinquent behavior (Jain & Cohen, 2013).

According to Rasmussen et al. (2004), coping with community violence usually requires an optimistic outlook on life and an even more robust view of one's locus of control (Rasmussen et al. 2004). However, due to the amount of fear that many adolescents feel when exposed to community violence, it can be challenging to cope appropriately. They found that African American and Latino adolescents exposed to such violence are more likely to utilize a confrontative approach to cope that aggressively tries to solve the problem. Adolescents may use this strategy by making a conscious effort to receive emotional and social support from others (Rasmussen et al., 2004).

In a study specifically focused on exposure to violence on the African American population on the Southside of Chicago, researchers wanted to obtain more information on the types of community violence faced and learn better coping strategies for every kind of community violence. Researchers, Voisin et al. (2011) chose to do this study in a Chicago neighborhood on the

Southside because there is a violent exposure that this community endures, from murder, manslaughter, robbery, rape, and assault. Through empirical research, the researchers found that there were five different coping strategies that these individuals used: “getting through,” “getting along,” “getting back,” and “getting away.” Out of all these strategies, the most used techniques were “getting along” and “getting through.” “Getting through” was described as accepting that the community they live in is filled with violence, putting in efforts to not think about this, and even possibly using school to avoid being in the community. “Getting along” was described as familiarizing themselves with the “right people” or people that can provide them protection from this violence or having a lot of friends and acquaintances (Voisin, Bird, Hardestry, & Shiu, 2011).

Chapter 3

Research Design and Method

Design

The proposed study was in the form of an observational cross-sectional study. This study was observational because the researcher will be observing the variables of this study and not manipulating them. This study was cross-sectional because it is a case-control design where the researcher's subjects will be selected and assessed by the characteristic of age (Kazdin, 2003).

Participants

A sample of 334 adolescents aged between 15 through 18 years participated in this study. Inclusion criteria were (a) adolescents between the ages of 15 through 18 and (b) students who were in high school. Equal gender distribution was aimed for, and a sample of 51.8% males and 48.2% females was achieved.

Measures

Demographics

A demographic questionnaire was administered before the actual testing (Appendix A). This questionnaire assessed if the participant met the criteria for the study. The questions on this questionnaire focused on the participant's age, gender, and ethnicity.

Symptoms of Depression

The Children's Depression Inventory- Second Edition (CDI-2) was administered to assess each participant's depressive symptoms. The CDI-2 is a self-report measure for children ages 7-17, consisting of 28-items that were divided into two scales: Emotional Problems and Functional Problems. These categories were also separated into four subscales: Negative Mood/Physical Symptoms, Negative Self-Esteem, Interpersonal Problems, and Ineffectiveness. Each item in this

measure contains four different statements organized in increasing severity regarding symptoms of depression. The participant is to choose which statement they feel describes them best over the past two weeks. The Total Scores of this measure would reflect the overall number of depressive symptoms each participant has felt within the past two weeks (Kovacs, 2011).

Exposure to Community Violence

The Screen for Adolescent Violence Exposure (SAVE) assessed each participant's exposure to violence. The SAVE is a measure that consists of 32-items that assess for exposure to violence in the neighborhood. Participants are to rate how often they have been exposed to indirect violence and direct violence on a 5-point Likert scale. Indirect exposure is described as violence that was not directed to the participant; however, it was violence that the participant witnessed. Direct exposure is defined as an act that the participant was directly impacted by. The total score is based on the summation of all responses to the items. The SAVE was found to have good test reliability and construct validity. This measure also demonstrated good internal consistency (α=.91) (Hastings & Kelley, 1997).

Resilience

The Child & Youth Resilience Measure- Revised (CYRM-R) assessed each participant's level of resiliency. The CYRM-R is a questionnaire that measures resiliency for children and adolescents ages 10-23. This measure is organized into 17 items in a Likert scale format, with an overall score indicating the individual's resilience. Some items included in the measure are: "I know how to behave in different social situations," and "My parent(s)/caregiver(s) really look out for me." The CYRM-R has an internal consistency of α=.82. This measure has been reported to have good face validity because it is a sensitive measure that considers social and ecological resilience factors (Resilience Research Centre, 2018).

Procedure

The Institutional Review Board (IRB) and Illinois School of Professional Psychology at National Louis University, Chicago, have conducted this research. The participants were recruited via snowball sampling, with recruitment fliers (Appendix A) posted at various adolescent-friendly establishments, such as community centers, restaurants, and specialty and grocery stores. Fliers were also posted on Facebook.com, Instagram, and Snapchat. Once a potential participant's parent proceeds to the SurveyMonkey page after clicking on the advertisement or entering the appropriate URL, they were presented with the informed consent form (Appendix B, and/or C, and/or D) that states whether or not they would like their child to participate. Once informed consent and assent have been obtained, and participants have been recruited, the researcher will use a survey monkey link to describe the research project's goal. Screening questions and eligibility criteria were also provided through this link. Participants completed all four questionnaires in the following order: demographic questions, CDI-2, SAVE, and CYRM-R. Participation in this study took no longer than one hour. Research participants received mental health resources, and contact information in case participants had questions about the study.

Statistical Analysis

For statistical analyses, IBM SPSS was utilized. Multiple regression was used to examine cross-sectional and longitudinal predictors of exposure to community violence, depressive symptoms, and resilience.

Data Preparation

Before performing the primary analyses, data were screened for normality, outliers, and missing values. During this process, respondents who did not give permission to do the survey were dropped. Little's test was performed to determine missing responses, and it was displayed

that these responses were “Missing Not at complete Random.” Respondents who stopped the survey at 50% or less were removed (Allison 2002). Therefore, leaving the final sample size at 334 respondents. Q9 was computed with three variables, one for each answer—combined the answers into one variable.

The CDI variables were recoded to reflect the 0-2 instead of the 1-3 on the dataset. The CDI items were reverse coded as per the survey questionnaire. The values were updated by removing by hand the new recoded and reversed coded items for the CDI. There were four subscales for CDI: Negative Mood/Physical Symptoms, Negative Self Esteem, Ineffectiveness, and Interpersonal Problems. For the SAVE part of the survey, the scale “Neighborhood Violence” adds the items together and divides them by the number of items. Cronbach Alpha Reliability (Cronbach, 1970) was performed, and this scale indicated a very reliable scale with an Alpha of 0.946. A “Resilience” scale was created by adding the items together and dividing by the number of items. Cronbach Alpha Reliability (Cronbach, 1970) was performed, and this scale indicated a very reliable scale with an Alpha of 0.930. Items that needed to be recoded were: Age with a dummy variable to compare Adolescents (under 18 =1) to those over 18 (=0), Gender: Female =1; Male =0, Race/Ethnicity: Dummy variables (white will be the comparison variable) Black, Hispanic, Asian, and Other which includes: American Indian, Alaska Native, Native Hawaiian, and Pacific Islander.

Chapter 4

Results

The focus of this study was to examine depressive symptoms, resilience, and exposure to neighborhood violence. The first aim was to determine if the CID subscales of Negative Mood/Physical Symptoms, Negative Self Esteem, Ineffectiveness, and Interpersonal Problems were related to the neighborhood violence. The second aim was to examine whether resilience was related to neighborhood violence exposure.

Descriptive Statistics

Table 1 presents the percentages and frequencies of categorical Variables. Most of the sample was over 18 years of age (62.0%). About 34.3% of the participants reported trauma. The majority of the sample was male (51.8%). 58.4% of the sample was white, 11.7% were Black, 9.3% were Asian, 6.6% were Hispanic, and 14.1% were from another race (other).

Table 1
Percentages and Frequencies of Categorical Variables

	Frequency	Percentage
Age		
15-17 years old	127	38.0%
18 or older	207	62.0%
Gender		
Male	173	51.8%
Female	161	48.2%
Race		
White	195	58.4%
Hispanic	22	6.6%
Black	39	11.7%
Asian	31	9.3%
Other	47	14.1%

N= 334

Table 2 presents the results for the continuous or scale study variables. The average negative mood score was just over a 6. The average negative self-esteem score was 5.449. The average ineffectiveness score was just over a 7. The average interpersonal problems score was just over a 4. The average neighborhood violence is 2.445, which indicates that just more than "hardly ever" to "sometimes" was given as a response. The average resilience is 3.066, demonstrating that just more than "somewhat" was the response.

Table 2.
Means and Standard Deviations

Variable	M	SD	Min.	Max.
Negative Mood	6.209	2.508	0	16
Negative Self-Esteem	5.449	1.786	0	10
Ineffectiveness	7.662	2.372	0	16
Interpersonal Problems	4.144	2.080	0	10
Neighborhood Violence	2.445	0.633	1	4.58
Resilience	3.066	0.746	1	5

n= 334

Multivariate Results

Table 3 presents the results of the multiple linear regression of Depressive Symptoms, Resilience, and Exposure to Neighborhood Violence Among Adolescents. Model 1 indicates that the Omnibus F-Test is statistically significant ($F = 20.357$, $df = 5, 321$; $p = .000$); which means the decomposition of the independent variables can proceed. The coefficient of determination (R^2 value) is .241. This value shows that the five independent variables can explain 24.1% of the variation in exposure to neighborhood violence in the equation. Utilizing the standardized Beta coefficient, it has been found that the higher number of negative mood/physical symptoms is related to more exposure to neighborhood violence ($B = 0.244$, $p = .000$).

Utilizing the standardized Beta coefficient, results indicated that the higher number of negative self-esteem is related to more exposure to neighborhood violence ($B = 0.128$, $p < 0.05$).

Utilizing the standardized Beta coefficient, the higher the number of interpersonal problems is related to more exposure to neighborhood violence ($B = 0.321$, $p = .000$). Utilizing the standardized Beta coefficient, it is the case that the more resilience that was endorsed, the more exposure to neighborhood violence there was ($B = 0.126$, $p < 0.05$).

Model 2 adds the sociodemographic variables to the equation. Model 2, the Omnibus F-test is statistically significant ($F = 10.945$, $df = 11, 315$; $p = .000$) indicating that the decomposition of the independent variables can be evaluated. The coefficient of determination (R^2 value) is .277. This value shows that the eleven independent variables can explain 27.7% of the variation in exposure to neighborhood violence in the equation.

Utilizing the standardized Beta coefficient, results indicated a higher number of negative mood/physical symptoms is related to more exposure to neighborhood violence ($B = 0.221$, $p = .000$). Utilizing the standardized Beta coefficient, it was found that the higher number of negative self-esteem is related to more exposure to neighborhood violence ($B = 0.147$, $p < 0.05$). Utilizing the standardized Beta coefficient, it was discovered that the higher number of interpersonal problems is related to more exposure to neighborhood violence ($B = 0.278$, $p = .000$). Utilizing the standardized Beta coefficient, the more resilience that individuals endorsed, it was attributed to the higher exposure to neighborhood violence ($B = 0.115$, $p < 0.05$). Among the eleven independent variables, it is the case that Asian youth are more likely to experience exposure to neighborhood violence compared to white youth ($B = 0.142$, $p < 0.05$).

Table 3.

Multiple Linear Regression for Depressive Symptoms, Resilience, and Exposure to Neighborhood Violence Among Adolescents

	Model 1			Model 2		
Variable	B	*SE(B)*	*B*	B	*SE(B)*	*B*
Constant	1.112***	0.236		1.154***	0.240	
Subscales of CDI: Negative Mood/Physical Symptoms	0.061***	0.016	0.244	0.055***	0.020	0.221
Negative Self-Esteem	0.045*	0.202	0.128	0.052	0.016	0.147
Ineffectiveness	-0.004	0.016	-0.017	-0.003	0.016	-0.011
Interpersonal Problems	0.096***	0.016	0.321	0.084***	0.017	0.278
Resilience	0.107*	0.047	0.126	0.097*	0.047	0.115
Adolescent (15-17 years old)				-0.116	0.063	-0.089
Female				0.060	0.062	0.048
Black				0.150	0.099	0.076
Hispanic				0.149	.0125	0.059
Asian				0.315*	0.111	0.142
Other				-0.015	0.092	-0.008
N	334			334		
F	20.357***			10.945***		
R^2	0.241			0.277		

Note: *< p .05; **< p .01; ***< p .001, two-tailed tests.

Chapter 5

Discussion, Implications, Limitations, and Conclusion

Discussion

This cross-sectional study aimed to examine whether adolescents who have been exposed to community violence were more likely to develop depressive symptoms. If adolescents do not endorse depressive symptoms, their resilience levels are high. As expected, the overall findings showed a clear relationship between adolescents that feel negative mood/physical symptoms of depression due to their high level of exposure to community violence. The study also found that those who endorsed negative self-esteem were more likely to be exposed to community violence. Individuals who endorsed more interpersonal problems also experienced more community violence. The more resilience adolescents had is related to the higher exposure to community violence they endured.

Interestingly, there was no significant impact of Ineffectiveness on those exposed to community violence. In other words, adolescents who have experienced community violence are less likely to feel that they are useful due to their sense of hopelessness. It is essential to acknowledge that many of the participants of this study were male adolescents. Moreover, the results of this study indicate that those who considered themselves more resilient also experienced a significant amount of exposure to community violence. The depressive symptoms that the adolescent participants of this study endorsed can be at least partially rationalized by the exposure to the dangerous environment they have or currently reside in.

Implications

The clinical implications of understanding the mental health effects of community violence on adolescents are substantial. This study suggests that several adolescents by the age of 18 will

have been exposed to some form of community violence. The study also demonstrates that adolescents who have experienced community violence are more likely to experience depressive symptoms, such as negative mood/physical symptoms, negative self-esteem, and interpersonal problems. Despite the resilience displayed by those adolescents who participated in this study, it can be explained that depressive symptoms are felt by those exposed to community violence often. The results of this study suggest that more time and effort should be taken into creating a more peaceful community setting for all people, especially adolescents. Future interventions should focus on understanding the adolescent's living environment.

Interventions should also focus on what protective factors, such as peer, family, educational, cultural, and community supports; they can rely on (Woods-Jaeger et al., 2020). A therapeutic approach that has been widely researched and is empirically supported to help adolescent victims of community violence is trauma-focused cognitive behavioral therapy (TF-CBT). This approach is useful with trauma because it primarily focuses on reframing, exposure, and behavioral techniques (Voisin & Berringer, 2014).

Interventions that may be helpful with adolescents experiencing the mental health effects and depressive symptoms of being exposed to community violence would be providing psychoeducation, possibly in the school and community settings. Psychoeducation would be helpful for those affected by such trauma to understand the commonality and severity of their symptoms, teaching more appropriate coping mechanisms and how to prevent crises. Traumatic bereavement therapy is also recommended, as it is a form of grief counseling that may help address losses endured due to community violence. In some instances, psychopharmacological medications may also be useful for victims of community violence with specific symptoms of depression, post-traumatic stress, and anxiety (Voisin & Berringer, 2014). Interventions focused

on helping adolescents feel more connected in healthy and safe environments would also provide an outlet and more positive outlook to be made aware of their resources and supports (Jain & Cohen, 2013). Parent training and psychoeducation may also be worth trying for parents to know how to help their children through the struggles of being exposed to community violence. Assessment tools that address the difficulty of adolescent disclosure or lack thereof may also be helpful (Alers-Rojas et al., 2020).

Limitations

There are several limitations of the present study that should be acknowledged. First, several individuals could have met the study requirements. Therefore, it is unknown where the study participants are from because that was not a part of the demographics criteria. Second, although the sample size was considered large enough, an even larger sample size would provide more generalized results. Additionally, this study was quantitative with self-report measures that may bring about individuals' specific biases about their mental health.

Furthermore, given that the study touched on sensitive subjects, such as exposure to community violence, depression, and resilience, the measurements could have been affected by under or even overreporting. It is important to note that desensitization may occur for those with prolonged exposure to community violence. Finally, future research is also recommended to involve older populations to address the effects that exposure to violence may carry on into adulthood.

While acknowledging these limitations, the results that emerge from the analysis of this study provide strong evidence of the relationships between depressive symptoms in adolescents and their exposure to community violence. Future research should include other types of adversity

and different contexts, such as home and school violence and their effect on adolescent mental health.

Conclusion

Given the current concerns regarding adolescent mental health, the main contribution of this study was to show that exposure to community violence can have serious mental health outcomes for adolescents who do not have strong or high resilience levels. It may also be the case that those who experience some form of community violence can also become more resilient due to the trauma they have experienced. Other studies are needed for more thorough detail on what resilience factors are most helpful for exposure to community violence. The study confirms that adolescents exposed to community violence are more likely to develop depressive symptoms. However, given the study's limitations, the results must be interpreted with caution and will need to be replicated.

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Appendix A

Demographic Questionnaire

Do you agree to participate?

- Yes, I agree to participate. (continue to survey)
- No, I do not wish to participate. (end survey)

What is your age in years? (in years)

_____ years

What is your gender identity?

- Male
- Female
- Non-Binary
- Non-conforming
- Other (please specify)

Appendix A
Recruitment Flyer

Do you have 40 minutes?

Wanna join a raffle to win one of four Visa gift cards?

Participate in a survey!

(about community violence and resilience)

{Insert SurveyMonkey Link here}

Appendix B

Informed Consent Form

Dear Parent/Legal Guardian,

I am a 5th-year student in the Doctor of Clinical Psychology program at the Illinois School of Professional Psychology at National Louis University – Chicago. I invite you to participate in my Clinical Research Project, which is similar to a doctoral dissertation. I am seeking to explore the relationship between adolescent exposure to community violence, depression, and the ability to overcome challenges. This study is a requirement for my doctoral degree and has been approved for distribution by my research committee and the National Louis University Institutional Research Review Board (IRRB). The survey is anonymous, so you will not be asked for any personally identifying information if you choose to participate. It should take about 60 minutes to complete online, and the risk for emotional harm to your child as a participant is anticipated to be minimal. Upon completing the study, survey participants can be entered into a drawing to win one of four $25 Visa gift cards in exchange for their e-mail address which will not be linked to their survey responses. The researcher(s) will secure the completed surveys in a Survey Monkey's platform connected account to ensure confidentiality. The data will be destroyed after three years, and each participant's e-mail address will only be used in the context of this study and will not be shared with anyone else.

Your child's participation is also completely voluntary, and you may choose to stop taking the survey at any time with no consequences or punishments to you. Furthermore, should you want to be informed of the study results at its conclusion via e-mail, the e-mail address you provide for participating will not be linked to your survey responses.

If you have any questions or want additional information about the study, please contact me, Nieves Esquivel, at [redacted] or at [redacted]

Suppose you have any other questions or concerns about the study or your child's rights as a participant before or during your participation that has not been addressed. You may also contact my faculty chairperson, Dr. Charles Davis, cedphd@sbcglobal.net, or the co-chairs of NLU's IRRB: Dr. Shaunti Knauth at shaunti.knauth@nl.edu and (312) 261-3526 or Dr. Kathleen Cornett at kcornett@nl.edu and (844) 380-5001. Both co-chairs hold offices at National Louis University, 122 South Michigan Avenue, Chicago, IL, 60603.

Thank you for your time in reading this message. I hope that you will participate in this research project. It would help understand what effects may follow when teenagers experience community violence and what can be done to prevent these effects. If your child is willing to participate and meet the above-stated criteria, please indicate your consent to access and begin the survey.

Consent: I understand that by checking "Agree" below, I acknowledge my participation in this study is entirely voluntary and will include completing an online survey taking approximately 60 minutes to complete.

ELECTRONIC CONSENT: Please select your choice below. You may print a copy of this consent form for your records. Clicking on the "Agree" button indicates:

- I have read the above information;
- I voluntarily agree to have my child participate;
- I am 18 years of age or older

☐ Agree

☐ Disagree

Appendix C

Informed Consent Form for Students 18 years of age

Dear participant,

I am a 5th-year student in the Doctor of Clinical Psychology program at the Illinois School of Professional Psychology at National Louis University – Chicago. I invite you to participate in my Clinical Research Project, which is similar to a doctoral dissertation. I am seeking to explore the relationship between adolescent exposure to community violence, depression, and the ability to overcome challenges. This study is a requirement for my doctoral degree and has been approved for distribution by my research committee and the National Louis University Institutional Research Review Board (IRRB). The survey is anonymous, so you will not be asked for any personally identifying information if you choose to participate. It should take about 60 minutes to complete online, and the risk for emotional harm to your child as a participant is anticipated to be minimal. Upon completing the study, survey participants can be entered into a drawing to win one of four $25 Visa gift cards in exchange for their e-mail address which will not be linked to their survey responses. The researcher(s) will secure the completed surveys in a Survey Monkey's platform connected account to ensure confidentiality. The data will be destroyed after three years, and each participant's e-mail address will only be used in the context of this study and will not be shared with anyone else.

Your participation is also completely voluntary, and you may choose to stop taking the survey at any time with no consequences or punishments to you. Furthermore, should you want to be informed of the study results at its conclusion via e-mail, the e-mail address you provide for participating will not be linked to your survey responses.

If you have any questions or want additional information about the study, please contact me, Nieves Esquivel, at [redacted] or at [redacted].

Suppose you have any other questions or concerns about the study or your rights as a participant before or during your participation that has not been addressed. You may also contact my faculty chairperson, Dr. Charles Davis, at cedphd@sbcglobal.net or the co-chairs of NLU's IRRB: Dr. Shaunti Knauth at shaunti.knauth@nl.edu and (312) 261-3526 or Dr. Kathleen Cornett at kcornett@nl.edu and (844) 380-5001. Both co-chairs hold offices at National Louis University, 122 South Michigan Avenue, Chicago, IL, 60603.

Thank you for your time in reading this message. I hope that you will participate in this research project. It would help understand what effects may follow when teenagers experience community violence and what can be done to prevent these effects. If you are willing to participate and meet the above-stated criteria, please indicate your consent below to access and begin the survey.

Consent: I understand that by checking "Agree" below, I acknowledge my participation in this study is entirely voluntary and will include completing an online survey taking approximately 60 minutes to complete.

ELECTRONIC CONSENT: Please select your choice below. You may print a copy of this consent form for your records. Clicking on the "Agree" button indicates:

- I have read the above information;
- I am 18 years of age or older

☐ Agree

☐ Disagree

Appendix D

Assent Form

My name is Nieves A. Esquivel. I go to the Illinois School of Professional Psychology at National Louis University, Chicago. I am inviting you to participate in a research study about adolescent exposure to community violence, depression, and the ability to overcome challenges. Your parent(s) know I am talking with you about the study. This form will tell you about the study to help you decide whether or not you want to take part in it.

What is the key information about this research study?

The following is a summary of this study to help you decide whether you want to be a part of this study. More detailed information is listed later on in this form.

The study is in the form of an online survey with 82 questions. These 82 questions will include questions about depression, your experience with community violence, and your ability to overcome difficult situations. The study should take no more than an hour to complete.

The purpose of the study is to understand the effects of depression on adolescents that may happen because of exposure to violence. You will be asked to complete an online survey of 82 questions. We expect that completing the online survey should only take 25 minutes. The primary risk of participation is the negative feelings about answering these questions, such as feelings of sadness, anger, or anxiety. The main benefit is that you would be helping the researcher gather information on how to be more helpful toward the adolescent population that experiences community violence.

Why is this study being done?

You are being asked to participate in the study because you are an adolescent and are likely to have been exposed to violence within your community. You cannot participate in this study if you are over 18.

What do I need to do?

If you decide to be in the study, I will ask you to take an online survey of about 82 questions. These questions will be about your experience with violence within your community, depression, and challenges you have been able to overcome. The survey should only take you about an hour to do.

What are the benefits to me?

Taking part in this study may not have direct benefits for you. Still, it will help me learn about the effects of community violence on adolescents and give other researchers and people that work in the mental health field more reason to create interventions to help you and other adolescents in need of help. You also can be entered into a drawing to win one of four $25 Visa gift cards.

Are there any risks to me if I decide to be involved in this study?

There are no foreseeable risks; however, some adolescents may feel negative feelings such as

anger, sadness, and anxiety. If you feel uncomfortable at any point while taking the survey, you can stop or withdraw from the survey without any negative consequences or penalties.

How will my information be protected?

Your responses will be anonymous. The results of this study may be used in reports, presentations, or publications, but your name will not be used. The data will be stored in a password-protected computer and flash drive. The only people that will have access to the data are the researcher and the research team. The data will be retained until the researcher's dissertation is published.

Do I have to be in the study?

No, you don't. The choice is yours. Your participation in this study is entirely voluntary. No one will get angry or upset if you don't want to do this. And you can change your mind anytime if you decide you don't want to be in the study anymore.

What if I have questions?

If you have questions about the study, you can ask me now or anytime during the study. You can also call me at [redacted] or e-mail me at [redacted] You can also reach my dissertation chairperson, Dr. Charles Davis, Ph.D., at cedphd@sbcglobal.net or the co-chairs of NLU's IRRB: Dr. Shaunti Knauth shaunti.knauth@nl.edu and (312) 261-3526 or Dr. Kathleen Cornett at kcornett@nl.edu and (844) 380-5001. Both co-chairs hold offices at National Louis University, 122 South Michigan Avenue, Chicago, IL, 60603. You will receive a copy of this form for your records.

Signing below means you have read this form and are willing to be in this study.

Name of the Participant (Write your name on the line):
_____

Signature of the Participant (Put your signature on the line):
_____

Date: _____

Appendix E

Information for Adolescents

Title of Study: The Relationship between Adolescent Exposure to Community Violence, Depressive Symptoms, and Resilience
Researcher: Nieves A. Esquivel
Phone Number(s): [redacted]

What is a research study?
A research study is a way to find out new information about something. Children/adolescents do not need to be in a research study if they don't want to.

Why are you being asked to be part of this research study?
You are being asked to take part in this research study because we are trying to learn more about the psychological effects that occur when adolescents are exposed to community violence.

What are the criteria to be in the study?
To participate, you must be between the ages of 15 through 18; and live in Northwest Indiana. Your involvement in and responses will be kept as confidential as possible, and the data will be reported in complete form, further protecting your responses.

We want to tell you about some things that will happen to you if you are in this study.

- We will need you to take an online survey that will last from 40 minutes to an hour.
- We will ask you to answer some questions about your exposure to community violence, depressive symptoms, and resilience levels.

Will any part of the study cause harm? This study is not meant to harm anyone. Suppose you have negative feelings such as anger, sadness, or anxiety while doing this survey. You can choose to stop or take a break and consider the resources provided to you by the researcher.

Will the study help you? The benefits of this study are that there will be more information about the consequences of adolescent exposure to community violence, psychological effects that may occur due to this form of violence, and protective/resilience factors that may prevent such outcomes.

Will the study help others?
This study might find out things that will help other researchers, psychologists, mental health and social workers treat the psychological effects of adolescents exposed to community violence.

What do you get for being in the study?
You can rest assured knowing that you will have helped me learn about the effects of community violence on adolescents and give other researchers and people that work in the mental health field more reason to create interventions to help you and other adolescents in need of help. You will also have the option to be entered into a drawing to win one of four $25 Visa gift cards in

exchange for their e-mail address which will not be linked to their survey responses to ensure confidentiality.

Do you have to be in the study?

You do not have to be in the study. It's up to you.
No one will be upset if you don't want to do this study, and you will not be punished for not being in this study.

If you join the study, you can change your mind and stop being part of it at any time.
All you have to do is tell us.

This study was explained to your parents, and they said that we could ask you if you want to be in it. You can talk this over with them before you decide.

Who will see the information collected about you?

During this study, the information collected about you will be kept safely locked up. Nobody will know it except the people doing the research. The study information about you will not be given to your parents or teachers. The researchers will not tell your friends or anyone else. The survey is anonymous.

What if you have any questions or concerns?

You can ask any questions that you may have about the study. If you have a question later that you didn't think of now, you can call or have your parents call [redacted].

Appendix F

Survey

1. Demographic Questionnaire

Do you agree to participate?

- Yes, I agree to participate. (continue to survey)
- No, I do not wish to participate. (end survey)

What is your age in years? (in years)

_____ years

What is your gender identity?

- Male
- Female
- Other (please specify):

Which of these best describe your cultural/ethnic background?

- American Indian/Alaska Native
- Asian
- Black/African American
- Latino/Hispanic
- Mixed/Multiracial
- Native Hawaiian/Pacific Islander
- White/Caucasian
- Other (please specify):

Appendix G

Child & Youth Resilience Measure- Revised (CYRM-R)
(Resilience Research Centre, 2018).

To what extent do the following statements apply to you?
There are no right or wrong answers. Please pick one.

	Not at all (1)	A little (2)	Somewhat (3)	Quite a bit (4)	A lot (5)
1. I cooperate with people around me.					
2. Getting an education is important to me.					
3. I know how to behave in different social situations.					
4. My parent(s)/caregiver(s) really look out for me.					
5. My parent(s)/caregiver(s) know a lot about me.					
6. If I am hungry, there is enough to eat.					
7. People like to spend time with me.					
8. I talk to my family/caregiver(s) about how I feel.					
9. I feel supported by my friends.					
10. I feel that I belong/belonged at my school.					
11. My family/caregiver(s) stand by me during difficult times.					
12. My friends stand by me during difficult times.					
13. I am treated fairly in my community.					
14. I have opportunities to show others that I					

am becoming an adult and can act responsibly.
15. I feel safe when I am with family/caregiver(s)
16. I have opportunities to develop skills that will be useful later in life (like job skills and skill to care for others)
17. I enjoy my family's/caregiver's cultural and family traditions.

Appendix H

Acknowledgment and Dissemination of Results

Thank you for your participation in my research!

If you would like to be informed of the results of this study, please enter your e-mail address here. Please note: that your e-mail address will **not** be linked to your survey responses.

With great appreciation,

Nieves A. Esquivel