"The contamination of communities through pervasive violence."

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Overview: I am truly honored to participate in your national meeting. In the two years since my last visit to your wonderful country, I have thought often about the differences and similarities in the problems we deal with and the approaches we offer for their resolution. As a visiting professor to the Catholic University of Chile, I had the opportunity to meet and collaborate with scholars from that institution as well as from the University of Santiago, and the University of Chile. I was most impressed by the sophisticated manner in which the basic and applied scientists within our discipline and across related social sciences respect and complement each other. As a community psychologist and Editor of one of that discipline's journals in the United States, I was particularly impressed by how much further your nation compared to the Unitede States has advanced in understanding and applying community principles in the design of health and mental health interventions. I am delighted to have the opportunity to return to your country for two very selfish reasons. First, in our last visit, my wife and I made dear friends and colleagues whom we have missed. Second, the many things that I learn from each visit makes the work I do in the United States conceptually and clinically stronger.

Two years ago, for example, I visited several neighborhood health centers. At each center, I witnessed how your health care system maximizes its resources by involving family members in diagnosis, treatment and rehabilitation. In one instance, a burn victim's family was present when the wound was cleaned and re-bandaged so that they might learn to identify signs of infection and assist in caring for the wound. At another center, I consulted on a case involving

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cocaine addiction (pasta base). Before I heard about the patient's history of drug use and indices of physiological tolerance, I received information about his family of origin, his current nuclear family, his educational and work history and his ties to parents, siblings, spouse and children. At that center, addiction was understood as effecting not only the patient but those within the multiple systems within which he lived and worked. Involvement of elements of those systems was assumed to be necessary if treatment was to be successful. At yet another medical setting, my wife and I sat in with members of a support group for ulcerative colitis patients organized by Dr. Marianne Krause. This group provided an additional example of the many ways in which principles underlying community processes are incorporated within the design and application of treatment and prevention programs in this country.

Of the many examples of such linkages, none had greater impact on me than my visit to a neighborhood health center's pediatric care unit. Since that visit, I have frequently described to colleagues and health care policy makers at the state and national level, Chile's commitment to providing comprehensive pre-natal care for its citizens. One form which that commitment takes is the practice of providing well-baby visits to **groups** of mothers and infants rather than individual mother-infant pairs. That approach translates known social influence processes and empowerment methods into an intervention which seems to maximize participation in pediatric care in ways which have primary, secondary and tertiary preventive effects. It seems to create a natural support group of young mothers whose shared understanding of risk and protective factors for the health of their children significantly enhances the chance for positive health among all members of these families. By observing early signs and symptoms of disease in their own and other infants, mothers become broadly informed observers of their children's health. Presumably, each mother also becomes an information source for her family and neighbors. The pediatricians with whom I spoke explained how the group visits were used to discuss parenting techniques with the young mothers, answer questions about caring for older children and generally provide to the mothers, and by extension, to their family and friends important health information.

In my view, this approach to serving young mothers illustrates the benefits of combining available knowledge about para-professional interventions, empowerment and social change processes. It can be applied to rich and poor alike be they in urban, rural or isolated areas of the nation. It provides each mother with substantial information which she can bring to members of her immediate and extended family and friends. Thus, it has the potential for geometrically expanding the public's awareness of current health related knowledge on topics of immediate relevance to specifically targeted segments of the population. It appears to have cross-generational impact on the immediate and long-term health of those with whom these mothers come into contact. It represents an ideal example of how limited professional resources can be optimized and how the seeds of early detection and treatment can be planted in fertile soil. It also suggested for me a means of involving high risk families in other preventive interventions targeted to risks beyond the prenatal and early childhood periods.

In recent months, my colleagues from education, family medicine, social work and clinical child psychology at the University of Pennsylvania and I have been discussing with local educators and health providers how we might adopt that strategy to improve the physical, emotional and educational functioning of low-income children. The Chilean pediatrician's approach to early pediatric care may assist the United States to reduce the risks of children born in low-income single-parent families, especially to unmarried adolescent mothers. Across multiple parameters of physical, emotional, cognitive and behavioral health, such children are at epidemiologically confirmed risk for many negative outcomes. Included among such risks, for example, are their increased vulnerability for becoming victims of physical and sexual abuse and, as I will explain in a moment, for being exposed to pervasive community violence (PCV). As we learn more about PCV, we are becoming increasingly clear about the breadth of its negative effects on children and their families. We are also becoming clear that we need to apply your systemic and community-wide understanding to that risk as well as to its consequences. In the time available, I will share with you my emerging understanding of PCV.

As I reflect on nearly a decade of work on issues related to children's exposure to and involvement with violence, it is apparent that the early stages would have benefitted greatly from consideration of a often repeated story. Reportedly, as the internationally respected author, Gertrude Stein, lay near death, a close friend leaned over and, in the hope of gaining one more bit of wisdom, asked:. "Gertrude .... Gertrude, please tell us, what's the answer?" Although very weak, Ms. Stein opened her eyes and in the slightest of whispers responded ".... what is the question?"

Those of us in the social, behavioral, developmental and educational disciplines should never lose sight of Ms. Stein's response. All too often we feel driven by the press of time to arrive at answers without completely understanding the question. Responding to expressed concerns of local educators and health care providers, I joined with them in a frantic attempt to solve the "problem of violence." With the best of intentions, we struggled to find solutions to problems whose parameters and implications we barely understood but felt impelled to solve nevertheless. Concerned about the common good, we seem to have lost sight of common sense. In our rush to fix what we perceived as broken communities, we failed to understand that within such communities, some breaks related to violence had:

a) been anticipated and avoided

b) occurred and been repaired;

c) occurred with little or no impact;

d) occurred and changed positively the community's climate; or

e) occurred and changed negatively the community's climate.

Our sense of urgency left us little time to recognize the variety of ways communities solve their own problems without outside help. Similar to the theme which underlies the approach to pediatric care represented in parts of your nation, we might have found instances of individual and community health and well-being and thereby learned about such community successes and strengths. Mothers without access to professional care (and even those with such access) regularly use resources from their families (e.g., mother, grandmother, mother-in-law) to care

for their child. The group approach offered by Chilean pediatricians mirrors as well as enhances that naturally occurring solution. Without understanding the question presented by the phenomenon of pervasive community violence, our proposed solutions rarely worked.

At this point, I am beginning to understand the question and to seek what I hope will be reasonable and workable solutions. PCV represents the fifth category of "break", i.e., one which has altered negatively the very fiber of community life and disrupts a wide band of community functioning. Solutions to PCV must focus beyond a child's home and family. Others in the community, indeed the "community" itself, must become involved as partners in finding and implementing solutions. I suggest that the answer to PCV lies in "Improvement **through** partnership".

Emphasis on "through" is most intentional. Much as I wish it weren't so, much as I wish that I or others could discover some particular mix of parent-neighbor-child-community activities which would neutralize PCV's toxicity and inhibit its contagion, I must admit to you (and to myself) that efforts in this regard are unlikely to succeed. After nearly three decades, I am convinced that solutions to the associated problems of community violence, substance involvement, academic failure, hopelessness, etc. will not be found in organized programs, however creative and solid they may seem. Findings from dozens of evaluation studies of community-based violence-prevention programs reveal that evidence that a program works under controlled conditions rarely generalizes when introduced into the real world of schools or neighborhoods. Often referred to as "bringing to scale", such dissemination studies regularly show that each school or community tailors the program to fit itself. In so doing, basic elements are changed enough to alter program impacts. Viable solutions to social problems such as PCV will not be found solely within an organized program implemented with fidelity across settings and situations. Try as we will, it seems unlikely that we will find solutions which, like the chemical formulae of prescription medications, can be applied in fixed dosages in easily swallowed capsules.

Having said that, let me state clearly that I am **not** suggesting that pressing social problems are insolvable. In fact, assuming its validity, I view the aforementioned conclusion as good news. To restate my assertion, I am proposing that the solution to lies not in **what** is done but rather in **how** what is done is done. I am referring to the **processes** by which a community's issues become understood and changed. The nature of those processes represents the central theme of my comments today. Partnership refers not to an agreement which specifies each member's duties. It does not refer to a set of instructions about who does what to whom under what circumstances, when and for how long. It cannot be viewed as a fixed prescription. **Partnership refers to the determination and refinement of the roles of all parties concerned within a context in which each party can take for granted the intentions, commitment and perseverance of every other party.** "Through" is defined in terms of the development and maintenance of the partnership.

Let me repeat, I believe that the social and behavioral sciences generally and the mental health, developmental and educational disciplines specifically, can contribute to the resolution of aspects of PCV within schools as well as within their host communities. After decades of seeking solutions within our disciplines and of highlighting their respective uniqueness, an increasing number of social and behavioral scientists (as well as health scientists) are appreciating their commonalities as well as their distinctions. The maturation of our disciplines is represented in our growing efforts to understand and respond to threats to the health and welfare of segments of the community through inter-disciplinary and multi-disciplinary methods. Based on my observations two years ago, I believe that your nation and discipline are further along in interdisciplinary collaboration than we in the US.

Progress is truly reflected in emerging exchanges of theories, perspectives and methods among these disciplines. But this early step is not sufficient to answer Ms. Stein's insight "...what is the question.?" Researchers and their settings (e.g., universities) seeking to understand a social issue, in this case the nature and consequences of PCV, must partner with the communities within which the issue arises and within which the elements of answers will be

found. Hence, the "schools" referred to in the title includes the universities, the colleges, the research institutes and other organizations through which we involve ourselves in the quality of a community's life.

If not part of the communities in which we work and to which research findings are to be applied, we social scientists risk providing partial or misguided answers. Our understanding will be incomplete because of limited access to information about the mechanisms by which PCV has evolved, is maintained and corrodes the lives of those it touches. Expressions of concern about an issue or community may gain us entre into a community but that is not equivalent to getting inside. Until we are no longer seen as "outsiders" or "visitors", we will see only part of the puzzle. At least that was case for me as I began working on PCV in response to a community's request that "something be done!"

Community sensitivity: Let me repeat what I said earlier: **"Partnership as used here refers to the continuing performance and refinement of the duties of all parties concerned within a context in which each party assumes the intentions, commitment and perseverance of every other party."** As I began working on the issue of PCV, I was confronted by community leaders' (e.g., school administrators, county health officer and representatives of mayor's office) reluctance to discuss their experiences with PCV and their resistance to conduct a needs assessment of its extent. I admitted that I, like they, had little sense of the nature, extent or full impact of PCV. I offered to work with them on developing measures of PCV and explained how we would use what we learned to design appropriate interventions. As my much admired colleague and valued mentor, Seymour Sarason Professor Emeritus at Yale University pointed out, H. L. Mencken's admonition that "for every major social problem, there's a simple answer that's wrong" must never be forgotten. The community leaders acknowledged that they did not even have simple solutions. My admission of a similar state of ignorance was met with relief and dismay. The former reflected their gratitude that I was not another academic who assumed that a solution was at hand with little direct understanding of the situation (echoes of Ms. Stein). The dismay, however, followed from my admission that one or more (or many more) years might be

necessary before we would be ready to "do something" (i.e., fix what is broken). This discussion led to an interesting exchange which I summarized in one of the papers resulting from that work. As I stated:

> "Can we as social and behavioral researchers genuinely ask communities to cooperate in the necessary research and accept that little may change for at least a decade? Can we ask them to abandon one or maybe two generations of their children until we are certain? In return will we commit ourselves to continuing involvement throughout whatever period of time is necessary? Will we do so without contingencies to that commitment such as "assuming the availability of funds" and "as long as I am on the faculty at ..."? In effect will we enter into a partnership with participating communities in which *they* but not *we* have the option to terminate the partnership?"
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> Our colleagues in the community raised such issues. From their perspective, collaboration involves more than *their* cooperating with the design and conduct of *our* data collection. Given *their* responsibilities, it also means that *we* are expected to assist them in determining the immediate and practical implications of the findings for program development and resources utilization. They recognize that doing so dilutes the "purity" of experimental designs. For them, however, scientific rigor must be balanced with social responsibility. In their view, evidence of *our* willingness to collaborate is reflected in our appreciation of the value of *their* priorities and *their* perspectives." (Lorion & Salzman, 1993, p. 63).

Gradually, the missing ingredient became clear, i.e., **time**. Much as they wanted an immediate solution, they wanted it provided within a relationship which had some history and, seemingly as importantly, some future. The history was antecedent to openness, disclosure and trust. I was not going to be privy to intimate aspects of their community as a stranger. The future was needed because they understood well the resistance of community problems to lasting solutions and because they had repeatedly collaborated with "committed" researchers departing mid-course as funding or interest shifted. How much time would be required for the process to evolve? My

Grandmother said it best to her ever-impatient grandson ... “you can’t hurry cake!” As we proceed to work with schools and communities in resolving problems such as (but not limited to) PCV, a first step is developing a shared understanding of the problem. That step takes time and the press of funding application deadlines and the peculiarities of the differing academic and fiscal years of universities, public schools and public agencies cannot alter the need for us to get to know each other.