

**Fostering Resilience in Traumatized Communities:
A Community Empowerment Model of Intervention**

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Abstract

This paper describes the history, composition and community intervention activities of the Community Crisis Response Team (CCRT) of the Victims of Violence Program and the community empowerment model of intervention that guides its work. The paper uses a single case study to illustrate the nature of community-wide trauma, the core attributes of ecologically informed and effective community intervention and the intervention design, implementation and evaluation processes that are embedded in the community empowerment model. The paper

includes a description of the CCRT's approach to the conduct of traumatic stress debriefings and a discussion of the practical and theoretical implications of the CCRT.

INTRODUCTION

Community Trauma: A Case Example

An 18-year-old high school graduate is fatally shot while walking to a bus stop near the housing development where he grew up.¹ Across the street several young children are playing in a neighborhood playground. Nearby, a group of city officials are meeting with a gathering of elderly residents, and, within earshot of the shooting employees and customers of a neighborhood grocery store quickly become terrified witnesses to the chaos that follows: the sirens, the panic and confusion, and the terror that, for some, vividly recalls other violent events.

According to neighborhood residents, this young man and his family were well known and well liked. He had been a varsity athlete at his high school and since graduating had been coaching neighborhood youngsters from all segments of this ethnically and linguistically diverse community. He was related to a former city council member, and his grandmother was an active participant in housing and neighborhood development programs.

This was the fourth of five murders that occurred within a two-month period in a city where crime is on the rise, but homicide is still a rare event. In its wake, a number of community groups were profoundly affected: members and friends of the victim's large and extended family, neighborhood residents and workers, children on the playground when the shooting occurred, their families and friends; teachers and school administrators who feared that at least

some of these children had witnessed the shooting; and, the victim's own friends, coaches, teachers. Also affected was a community group unknown to the victim, namely, a group of high school seniors who were about to begin running summer camp programs for children in the neighborhood. Many of these students felt completely unprepared to assist children who may have been present at or affected by the shooting. Some feared for their own physical safety.

Violent crime can have traumatic impact on entire communities, and on many different segments of affected communities. In the aftermath of violence, any number of community settings may become focal points of intervention. Crisis teams may enter a school or workplace following a shooting that has been witnessed by students or co-workers, for example, and trauma experts may meet with various at-risk and affected community groups. Indeed, community crisis response has become rather standard fare in the experience of communities affected by catastrophic events (Raphael, 1986; Dyregrov, 1997; Norris and Thompson, 1995; Paton, 1995; Kaplan, Iancu, and Bodner, 2001). Despite the best efforts of many crisis respondents, however, an increasingly divided literature cautions that even the most well meaning community interventions can have harmful rather than helpful effects (Raphael, Meldrum and MacFarlane, 1995; Rose and Bissen, 1998; McNally, Bryant and Ehlers, 2003). Moreover, communities differ considerably in their need for and receptivity to outside intervention .

Responding to Community Trauma

In the days and weeks following this homicide—during which time no suspect was named, no assailant apprehended-- many affected communities learned of and sought assistance from the Community Crisis Response Team (CCRT)² of the Victims of Violence (VOV) Program. Each request was assessed and responded to by the team's core administrative staff who, in turn, worked with community representatives to consider if and how the CCRT might be helpful, to plan interventions tailored to the needs, resources, values and traditions of each "client community" and to consider who among the team's many volunteer

members might participate. Team members familiar with the neighborhood were asked about community demographics and relationships among various segments of the community, for example. Team members fluent in Spanish, Portuguese and Haitian-Creole and those who were licensed mental health professionals with expertise in working with children or the elderly were asked to be available for one or another interventions on behalf of specific groups.

Over time, the CCRT implemented several responses. Soon after the event, for example, the CCRT Coordinator consulted with city officials, the manager of the housing development and leaders of its tenants' association to plan a timely and informative community meeting. Team members fluent in various languages later attended that meeting as translators and support personnel. Over the next several weeks, some staff and team members conducted a traumatic stress debriefing with employees of the neighborhood grocery, while others met with a group of Central American immigrants who had experienced significant violence in their homelands. At these events, licensed clinicians provided support to particularly distressed individuals and, as needed, made referrals to clinical care. Finally, a series of workshops on children and traumatic stress was offered to students preparing to work with neighborhood children.

The Community Crisis Response Team

The array of interventions that followed this young man's death is illustrative of the work of the Community Crisis Response Team, a service of the Victims of Violence (VOV) Program. VOV services are designed to foster recovery through the promotion of choice, self-determination and social action ((see Harvey, this issue). Within VOV, the aims of community intervention post-trauma are to address the community's vulnerability, augment and enhance existing community resources and promote community-wide coping and healing. An outcome goal of every CCRT interventions is its ownership by the client community.

The Team:

The CCRT was established by VOV in 1988, in recognition of the devastating impact that violent crime can have on affected communities. Through the CCRT, a small coordinating staff organizes the work of more than forty volunteer members drawn from mental health, criminal justice, religious, educational, social service and victim advocacy agencies and organizations throughout Boston, Cambridge and the surrounding four-county area. Together, CCRT staff and team members extend confidential crisis response and consultation to communities and community settings affected by violent crime

The CCRT Staff: Staff of the CCRT include a full-time coordinator who is a licensed clinical social worker and two part-time community liaison staff: an emergency mental health worker with a local hospital and a senior community police officer, both former volunteer members of the CCRT. The Coordinator is a member of VOV's core staff and a key participant in hospital and departmental crisis response planning forums.

CCRT Volunteers: Volunteer members of the CCRT include specialists in such areas as victimization, crisis intervention, and the treatment of psychological trauma, people with experience and expertise in working with specific populations (e.g. children, the elderly, recent immigrants) and individuals with longstanding records of neighborhood activism and community leadership. Team members are recruited not only from diverse agencies and organizations but also from racially, culturally and linguistically diverse communities, further enhancing the CCRT's ability to respond to a wide variety of groups and situations. In addition, team members are recruited from particularly vulnerable communities (e.g. high crime neighborhoods, immigrant and ethnic minority communities) and often from more than one agency or organization in urban neighborhoods afflicted by recurrent episodes of violent crime. A goal of this "cluster recruiting" is to contribute to the long-term development of a given community's crisis response capabilities: first, by helping to develop the crisis response skills of community members, and, secondly, by facilitating their exchange of ideas and expertise and encouraging them to network with one another and utilize their CCRT training in off-team situations.

The CCRT Contract: CCRT staff limit their recruitment of team members to individuals whose organizations contract with VOV to sponsor a volunteer member for a term of at least one year. CCRT volunteers are salaried by their sponsoring agencies and receive release time from their workplaces to participate in CCRT interventions and training. The contract specifies that those team members who are licensed mental health professionals will be covered by the sponsoring agency's professional liability insurance. Team members commit to being available for 8 to 10 hours of community crisis response activity during a membership year.

Team Training and Team Building:

Entry onto the CCRT begins with an intensive 2-day training that includes both didactic presentations and experiential exercises covering a range of topics, including the nature of acute and chronic trauma, crisis intervention skills, principles of community-level intervention, working with special populations and the CCRT's community empowerment model.

Following the initial training, team members participate in monthly team meetings where CCRT interventions are reviewed and additional training and support is provided. These meetings serve many purposes: skill development, supervision, evaluation of recent interventions, and the ongoing development of the CCRT itself. Through their involvement in these meetings, team members become active participants in a unique network of community resources -- agencies, groups, and individuals-- that they may call upon off-team in many capacities, including their work-related capacities. Not surprisingly, the CCRT has evolved into its own kind of community: a community with a diverse and now multi-generational membership joined by common purpose, shared values and well-established traditions (Yassen, 1995).

Precipitating Events and Client Communities:

The kinds of incidents that result in requests for CCRT assistance are varied. They include:

- Incidents occurring in communities in which people are strongly affiliated with one another (e.g. a school, a workplace, a church or a neighborhood);
- Incidents in which there are multiple direct victims and/or eyewitnesses;

- Incidents in which the victims (or perpetrators) have a special significance to the affected community, as might happen with the violent death of a child or community leader;
- Incidents involving numerous emergency or rescue workers, and
- Incidents that attract a great deal of media attention.

Since the CCRT's inception in 1988, events precipitating requests for CCRT assistance of course have included catastrophic events like the terrorist attacks of September 11th when representatives from host settings called upon the team for crisis response, consultation and training. More often, however, the CCRT is called upon when sadly more familiar crimes of violence -- rape, family violence, child abuse, elder abuse, hate crime or murder – send waves of shock through one community setting after another. During one 24-month period, for example, over half of the more than requests received were precipitated by acts of homicide, double homicide, or homicide/suicide. Other events included sexual assault, physical assault, school violence, and the distress of service providers working with victims of extreme violence.

The Services of the CCRT:

Responding to requests from affected communities, the CCRT offers a range of confidential and time-limited crisis response services. Depending upon the needs and resources of a client community, these may entail any/all of the following:

- Consultation to community settings as they plan and implement their own crisis response

activities: The CCRT Coordinator may meet with school administrators, workplace managers, or neighborhood representatives to help them think through what they want to do, when and for whom. These meetings often involve considerations such as how to deal with the media, how to handle “rumor control” and if, when and how to structure community meetings and group interventions. Community consultation encourages community representatives to step back from the crisis at hand, slow the response process down a bit and take the time needed for developing thoughtful, well-considered interventions, making

use of familiar resources whenever possible. The goal is to help communities mobilize and direct their own crisis response resources. Often, community consultation is the only --or, at least, the primary-- service provided by the CCRT.

- Direct assistance to affected community members and groups: Direct services of the CCRT are offered only after an initial period of consultation and collaborative needs assessment and rarely occur within the first 24 to 72 hours of an incident. These services may include: co-leadership of large or small community meetings, coordination of CCRT interventions with those of other crisis response groups, mental health needs assessment and clinical referral, group interventions and traumatic stress debriefings for small groups of individuals who are usually well-known to one another or other modes of direct assistance. CCRT volunteers typically participate as members of two-to-three person intervention teams organized and supervised by CCRT staff. Virtually all direct interventions include the participation of a licensed clinician.
- The CCRT's Approach to Traumatic Stress Debriefing: The CCRT regularly reviews and modifies its direct service approaches. Initially, for example, the team's approach to traumatic stress debriefings borrowed both structure and intent from Mitchell's (1983) critical incident stress debriefing model – a model designed to prevent posttraumatic stress disorder among first-responders (i.e. police, firefighters, emergency medical personnel) to tragic, often horrifically tragic, events. Over the ensuing years, with a diversification of debriefing models (Paton, 1995; Dyregrov, 1997), an increasingly divided research literature concerning the preventive efficacy of post-incident debriefings (see, e.g., Rose and Bisson, 1998; Everly and Mitchell, 1999; Kaplan, Iancu and Bodner, 2001; McNally, Bryant and Ehlers, 2003) and the CCRT's own increasing involvement with chronically traumatized communities, this approach has been modified. Today, the emphasis is on creating a safe and containing forum where participants are supported as they review both personal and community reactions to one or a series of violent events, given information about normal

reactions to psychologically traumatic events, helped to identify resources that have proven useful in the past and encouraged to construct personally meaningful, affiliative strategies for future self-care. The focus is less on preventing PTSD among community residents than on educating community members about the impact of potentially traumatic events on themselves, their families and friends, heightening their awareness of available resources and confirming their collective membership in a caring community. CCRT debriefings are never mandatory, are preceded by considerable attention to issues of privacy, confidentiality, choice and safety, and often result in the self-identification of participants who are having a particularly difficult time, at which point CCRT respondents are able to provide timely referrals to appropriate clinical and/or community resources.

- Secondary traumatic stress workshops and peer support interventions on behalf of service

providers impacted by violence: When communities are impacted by crimes of violence, caregivers in these communities can become overwhelmed by a seemingly unbearable sense of responsibility and concern. (McCann and Pearlman, 1990; Yassen, 1995). Among those who may be most severely affected by acts of violence are caregivers who live and work in what we have come to refer to as “chronically traumatized” communities. These individuals serve on the front lines of community engagement with violence. They remind us that even the most seasoned among us can feel immobilized by the prospect of offering care in the wake of one more tragedy. So it is both in the immediate aftermath of a violent crime and in a sometimes ominous “lull” between one incident of violence after another that the CCRT may be called upon to meet with mental health providers, first responders and others who themselves are involved in the “heat” of crisis response. Typically the work takes the form of secondary traumatic stress workshops that combine peer support with didactic presentations on the nature of secondary trauma and signs of vicarious traumatization. (McCann and Pearlman, 1990; Yassen, 1995; Yassen and Harvey, 1998)

Follow-up support and assistance. CCRT's services are always time limited. They have a beginning, an end, and are implemented and concluded in collaboration with the client community. Follow-up support and assistance is always available, however. This may take the form of checking in with a community representative when new information about a criminal case is in the news, or, when a trial is about to begin. It may also involve an offer of support when a new incident has occurred within the same client community.

All services of the CCRT are offered free of charge and with guarantees of confidentiality. Moreover, while representatives of client communities may choose to introduce CCRT members at public gatherings, these team members are always present as guests of the community. They do not speak for a community and will generally decline media exposure. At other times and in other contexts CCRT staff may well consult with media representatives about CCRT services and/or how they might better educate the public about psychological trauma. Such consultations do not occur in the midst of a CCRT crisis response, however, when issues of community safety, trust, and privacy predominate.

The Community Empowerment Model

Figure 1 depicts the community empowerment model that guides the design, conduct and evaluation of all CCRT interventions.

Community Entry:

As indicated in figure 1, the CCRT's involvement begins when a request for assistance is received from an affected community and when a legitimate point of entry into the community has been established. Initial conversations between CCRT staff and community representative focus on the nature of the event that has occurred, what (if anything) the representative knows about the CCRT, and determining if s/he is in a position to speak for the community in question. The inquiries and exchanges taking place at this early phase of the intervention process lay the foundation for shared ownership of any intervention that is subsequently initiated.

A note about the CCRT's "Pre-Entry" Activities with Communities at Risk: Whatever services are ultimately offered to a client community, the work of the CCRT takes place year round as staff and team members reach out to organizations and groups throughout the metropolitan area. Outreach activities include distributions of CCRT literature, presentations to local agencies and community groups, year-round recruitment of new team members, on-going contact with sponsoring agencies, and week-in, week-out collaboration with anti-violence organizations and coalitions. It is noteworthy that over half of the requests received by the CCRT are initiated by individuals who had learned of the CCRT through an outreach presentation or who had knowledge of a previous CCRT intervention in their own or a nearby community.

Request Analysis:

Once a legitimate avenue of community entry and involvement has been established, the CCRT Coordinator (or designated staff) and client community begin the process of request analysis and mutual consultation . Questions considered during this phase include: What is the "trauma history" of the affected community? What individuals or groups are of greatest concern? How is the community's request changing as the request analysis process continues? What has been done thus far? What next steps have been planned? Request analysis with a community in crisis may last hours or days depending on any number of circumstances, including how and how rapidly things are changing within the community itself. Frequent telephone contact and face-to-face consultation give assurances of the CCRT's sustained concern and availability.

Identification of Community Resources and Resource Gaps, Clarification of CCRT Resources:

Request analysis typically moves rather seamlessly into a needs assessment phase in which existing community resources and resource gaps are identified, needs are prioritized and participants consider if and how the CCRT might provide additional assistance. The CCRT's work with the community may end during this phase, as is the case when it becomes clear that the community is already doing and knows how to do all that can or should be done at the

moment. In this event, the CCRT's contribution has been to serve as an outside source of reassurance and validation, providing support to the community's own crisis response planning and affirming the community's ability to address its own needs. In other cases, the process may highlight the need for continuing CCRT involvement.

Designing a CCRT Response:

When a community and CCRT coordinating staff agree that the team's continuing involvement could be a helpful element of the community's overall response, a response involving one or more direct CCRT services is formulated. If a traumatic stress debriefing or other group intervention is agreed upon, for example, or if the CCRT is to be present at or is to co-lead a community meeting, staff begin thinking about which team members to call upon, the roles they might play and how they might be identified to the larger community. Questions raised and answered at this point include: What will be done by the CCRT and what by the community? How might an anticipated media presence be dealt with? How and where will CCRT and community participants meet to prepare for and discuss last minute changes? Response design is always a shared process, with both CCRT staff and community representative deciding together what will be done, when, where and by whom.

It is during this phase of the empowerment model that the client community and CCRT staff begin to formally and informally identify desired outcomes. Outcome goals might include, the hope that a community meeting will be well attended by particular groups, for example, or that particularly at-risk community members will give voice to their concerns and become more aware of and likely to make use of important community resources, and/or, that members of an affected group will feel greater cohesion with one another following a CCRT intervention. These outcome goals, while relatively global in the early stages of involvement, become more refined as the process continues and are visited again, after the intervention is concluded, by all involved: community representative/s, CCRT staff, team members who have been directly involved in the intervention, and the team as a whole.

Implementing the Response/s:

As client community and CCRT staff become clearer about ways in which the CCRT might be helpful, the two entities begin planning the logistics of it all. The emphasis during this phase is always on maximizing the community's ownership of and responsibility for the intervention. When the composition of the CCRT's intervention team is established, its members are convened by the Coordinator who designates which team member will do what (e.g. give a presentation, serve as a translator, lead a group intervention, provide support or act as an observer of the intervention process). Licensed mental health clinicians involved in the intervention will include among their responsibilities the job of noticing individuals who seem severely distressed and, as appropriate, extending to them on-site crisis care and follow-up referrals. As CCRT staff prepare team members for their work, the community representative manages the logistics back home --- identifying the setting in which the intervention will occur, securing the involvement of other community members, preparing the environment, and, later, being on hand to welcome and introduce the CCRT respondents.

Many steps and considerations are involved in implementing and preparing to implement a CCRT response. These steps --from community entry to response implementation -- can actually be carried out in very brief span of time: typically, a few days to one or two weeks, but, if needed, within a few hours. Particularly when the timing is short and emotions are running very high, it is the framework provided by the community empowerment model that "holds" the CCRT and, by extension, the community.

Evaluation and Feedback

CCRT interventions come to a close with a multi-layered and collaborative evaluation process. As soon as possible, members of the intervention team meet, first, with one another and then with the CCRT Coordinator to evaluate how they think the intervention was conducted and received, how they are feeling about their own participation, what, if anything, they might have done differently and where things were left with the community. This part of the evaluation

process enables an assessment not only of the way in which a given intervention was conducted, but also of the developing skills and working relationships of intervention team members.

While the intervention team is reviewing its work, the community representative gathers feedback from community participants and meets with the CCRT Coordinator to review each intervention, determine whether or not previously agreed upon goals were or were not achieved and consider what next steps should be taken, if any. These might include checking in with one another about particularly distressed community members or developing additional services as new segments of the community register their concerns. For the CCRT, a major concern is with assessing the quality of the relationship that has been achieved with the client community.

A final part of the evaluation process involves both staff and team review. When the intervention (or a series of related interventions) is reviewed at a monthly CCRT meeting, the discussion will integrate feedback from the community and from team members involved in the intervention. Topics will include a consideration of the intervention's impact on the CCRT itself and implication for the evolving relationship between CCRT and client community.

Exit/Closure:

CCRT involvement with a client community ends with a final follow-up by the CCRT Coordinator and an expression of appreciation for the community's interest in the CCRT as a resource. At this point, the intervention is considered "over" and the relationship with a client community concluded. This final step is a key element of the empowerment model, one that reminds team members and community representatives alike that CCRT members are invited guests and that, as such, they are outsiders who need not and should not overstay their welcome. Leaving the community is as important a step as gaining entry into it. Leaving a community whose resources and strengths have been affirmed and engaged builds and reinforces community resilience. Among the most gratifying outcomes of the CCRT's work to

date has been the number of individuals who have joined the team precisely because of the way in which the CCRT intervened in –and exited from--their own communities.

The Empowerment Model in Action:

Returning to the case example with which we began this article, we know now that at the time of this homicide the CCRT was a resource known to some and unknown to others in the various communities impacted by the crime. The outreach and “pre-entry” work of the team had made some inroads into the community, and the recruitment of team members from diverse community settings had set the stage for legitimate community entry. Thus, a public health administrator who was herself a former team member, encouraged the manager of the housing development to contact the CCRT. In collaboration with this manager, the police department, other city officials, her department was trying to help organize a community meeting at which this homicide and other recent violent events would be discussed. After speaking with CCRT staff, she encouraged the housing manager to seek a consultation with the CCRT Coordinator on how to structure and conduct the meeting and how to address the concerns and contain the emotions of an anticipated audience of over 100 multi-lingual community residents. The CCRT was invited to be present as a support to the housing manager, and to provide residents with information about the CCRT, the VOV Program and other mental health resources in the community. Because of its diverse membership, the CCRT was able to provide bi-lingual translators and printed materials in several languages.

As additional requests came in, CCRT interventions also included crisis response planning sessions with city officials and neighborhood task forces, traumatic stress debriefings and other group interventions with neighborhood residents, and a series of interventions with the high school students who were about to begin the summer camp program with neighborhood children. In this instance the request came from an official of the high school program who had learned of the CCRT from an outreach presentation by the CCRT Coordinator earlier in the year. After an initial period of request analysis and consultation, this official and the

Coordinator agreed that the students could benefit most from an educational intervention to inform them about children's reactions to traumatic events -- how they are affected, what is a normal reaction, and what to look for—and to remind them that their job was to provide the children with a positive camp experience, not to try and serve as therapists or crisis counselors. Thus, the intervention also provided the students with information about clinical resources for children and the CCRT Coordinator identified team members who would be available to provide support to any of the students who became concerned about a child in their care.

As each of these responses was implemented, the CCRT Coordinator and liaison staff stayed in close touch with representatives of the various client communities. Plans were discussed and revised up until the last minute – as the expected number and demography of participants changed, for example, and as various community leaders weighed in on what might be the most helpful response to changing circumstances. During this time, outcome goals associated with the planned interventions changed as well. At one point, for example, a police presence was considered an important element of the community meeting. Later, because some community planners felt that a police presence might have an intimidating effect on some segments of the desired audience, a decision was made for the police to provide updates to identified community leaders who would, in turn, hold smaller follow-up meetings for specific groups of neighborhood residents. An initial goal of creating police-community dialogue was replaced by that of enabling a possibly more open and vibrant dialogue among residents and community leaders. CCRT staff provided consultation to community members on some of these decisions and, in others, simply adapted to changes decided upon by the community.

As each response was completed, feedback was gathered and reviewed with key participants. CCRT staff learned that a particularly valued element of the large community meeting was the CCRT Coordinator's ability to address those in attendance in both Spanish and English, and, also, that the CCRT's multi-lingual written materials had been readily consumed by persons attending the meeting. On the other hand, some CCRT team members felt the

meeting had gone on way too long, and some community residents were upset that the police had not been in attendance. Clearly, leaders of this meeting had not successfully conveyed to participants the plan for smaller, follow-up sessions. The workshops conducted with the high school seniors were reviewed in a particularly positive light by all involved. The students reported feeling less personally fearful, more prepared to work with the children, and strongly supported by both their advisors and CCRT members.

In the weeks that followed this young man's murder, the CCRT Coordinator stayed in touch with representatives of each client community until the CCRT's work was done and then conducted a review and evaluation of each intervention with community representatives and participating team members. A final step in the process involved review of all interventions arising from this one event by the CCRT membership at their regularly scheduled monthly meeting

Discussion

Both the CCRT and the community empowerment model that guides its work trace their origins and theoretical rationale to the ecological perspective of community psychology. Harvey, this issue). An ecological view of psychological trauma (Harvey, 1996) assumes that human reactions to adverse and traumatic events are best understood in the ecological context of human community and, further, that effective community interventions post-trauma are those that enhance the ecological relationship between community and community member. In the case of community crisis response, this perspective suggests that the efficacy of interventions undertaken post-trauma by outside experts and professionals will be realized (or not) in the extent to which they utilize, enhance, conserve and help to restabilize community resources (Hobfall, 1988; 1991; Hobfall & Lilly, 1993; Norris, Phifer & Kaniasty, 1994).

Consistent with this perspective, the CCRT can be viewed as an on-going effort to develop and enhance the diverse resources of traumatized communities. An act of extreme violence or shared community disaster can sorely tax and threaten to overwhelm existing

community resources. In the face of such threat, some community members may reach beyond the boundaries of local community in search of new resources, including outside consultation and assistance. Others, however, will resist outside influence and try to shield the community from the intrusions of media representatives, curiosity seekers, and/or “outside experts” who may have arrived uninvited only to be perceived as overbearing, inconsiderate and/or ill-informed (Koss & Harvey, 1991). Within this ecological mix of reactions to tragic events, each intervention launched in a community becomes part of its history and identity. One aim of empowering community intervention must be to make a positive contribution to a traumatized community’s crisis response resources and evolving identity.

Since the early 1970’s, research by community psychologists has examined the aims, nature, forms and efficacy of community level interventions (see, e.g. Heller and Monahan, 1977; Glidewell, 1977; Durlak and Wells, 1997; Rappaport and Seidman, 2000; see also Harvey, this issue). One way to conceptualize community crisis response is in terms of its preventive possibilities. Preventive interventions have aimed at health-promotion and risk reduction with vulnerable populations, the promotion of social change and environmental reform in social organizations and institutions, and, apropos to the work of the CCRT, the promotion of resilience in individuals and communities affected by adverse events (Cowen, 1994; Norris and Thompson, 1995; Durlak and Wells, 1997; Trickett, 1997; Harvey, this issue).

An early study of preventive interventions (Paster, 1977), found that effective preventive intervention efforts –i.e. those that realized their intended benefit and were adopted by the communities into which they were introduced – were distinguished by five attributes: (1) early and ongoing participation of community members in planning and carrying out the intervention; (2) a high assumption of responsibility for the intervention among community members served by it; (3) the ability of the interveners to see themselves as resources to the intervention activity, rather than as person deserving “credit” for it; (4) a focus on the strengths of individuals and settings identified as the targets of intervention; and (5) the creation of on-going and self-

renewing social supports to help build and maintain the competencies of community members involved in the intervention effort.

The first four of these attributes also describe core elements of the CCRT's Community Empowerment Model -- a model that borrows its goals, form and substance from the ecological analogy of community psychology (Kelly, 1987) and from the premise that community intervention in the aftermath of violence must have as a primary goal that of enhancing the relationship between affected individuals and the communities from they draw identity, belongingness and meaning (Norris and Thompson, 1994; Harvey, 1996, this issue). Every CCRT intervention, however configured and however rapidly initiated, is guided by this model: it has been designed to ensure that CCRT members always pay attention not only to the task of initiating particular interventions, but also to the crucial importance of securing and maintaining on-going community engagement. The fifth of these attributes describes the fundamental rationale for the CCRT's annual training, monthly team meetings and team member recruitment strategies. Together they ensure to team members and their sponsoring agencies recurrent opportunities for skill-development, social support and self-renewal.

In recent years, a number of community psychologists have turned their attention to the importance of creating evaluation tools and approaches that engage, educate and empower the communities that serve as host environments for community intervention (Fetterman, 1996; Suarez-Balcazar, et al, 2003; Fawcett, et al, 2003). Among these authors, Suarez-Balcazar, et al (2003) suggest that participatory and empowerment approaches to the evaluation of interventions enhance the likelihood that a client community will take ownership of the intervention and make use of the evaluation findings.

The empowerment evaluation literature has important implications for the CCRT. Currently, the evaluation of CCRT activities takes place at two levels. One is that required by the funding agency² and begins with an annual articulation of specific program goals and objectives, followed by a delineation of the number of communities served in a given year, the

services provided and the communities prioritized for CCRT outreach and team member recruitment, A second level of evaluation is participatory and collaborative and is embedded in the community empowerment model. Indeed, participatory evaluation of CCRT interventions is anticipated by each element of the empowerment model. At the very earliest phases of community engagement CCRT staff and community representatives mutually assess the needs of a community in crisis and consider what, if any, CCRT interventions are likely to benefit to community members These discussions ensure the collaborative design and implementation of targeted interventions and for the identification of mutually agreed upon outcome goals. They also give shape and content to a final series of intervention reviews that aim to engage client communities in an empowering evaluation process (Suarez-Balcazar, et al, 2003; Fawcett, et al, 2003) A future goal will be to make more explicit the connection between the empowerment model and the evaluation strategies recommended by these and other empowerment evaluation authors.

CONCLUSIONS

An ecological view of communities and community intervention suggests that we need to look not only at the helpfulness or harmfulness of specific interventions (e.g., critical incident stress debriefings.) but also, and perhaps more importantly, at the ways in which trauma-informed interventions are initiated and carried out in and with affected communities. To paraphrase community psychologist Jim Kelly's (1979), maybe "it's not [only] what you do, but the way that you do it". How professionals intervene in communities is as essential to the outcome of their efforts as what they do. . The CCRT's community empowerment model is a guide to the "how" of community crisis response – and to the "how" of staff and team member behavior with representatives of traumatized client communities.

Since its beginnings in 1988, the CCRT has developed in size and complexity, with many more members than originally intended and certainly more experience in the realm of trauma response than originally anticipated. Particularly unanticipated was the extent to which

the team would be working with what we have come to call “chronically traumatized” communities – i.e. urban communities in which recurrent violence may have devastating impact on already vulnerable community ecosystems. To achieve what community psychologists refer to as “ecological fit” between our interventions and the needs of our client communities, we have recruited and learned from team members within those communities about the meaning of events, the groups most severely impacted by them and the values, traditions and expectations that should inform CCRT behavior in these communities. These lessons are embodied in the community empowerment model, which not only guides the design, conduct and evaluation of all CCRT interventions but also links the task of time-limited community crisis response to the larger and longer-term goal of community development.

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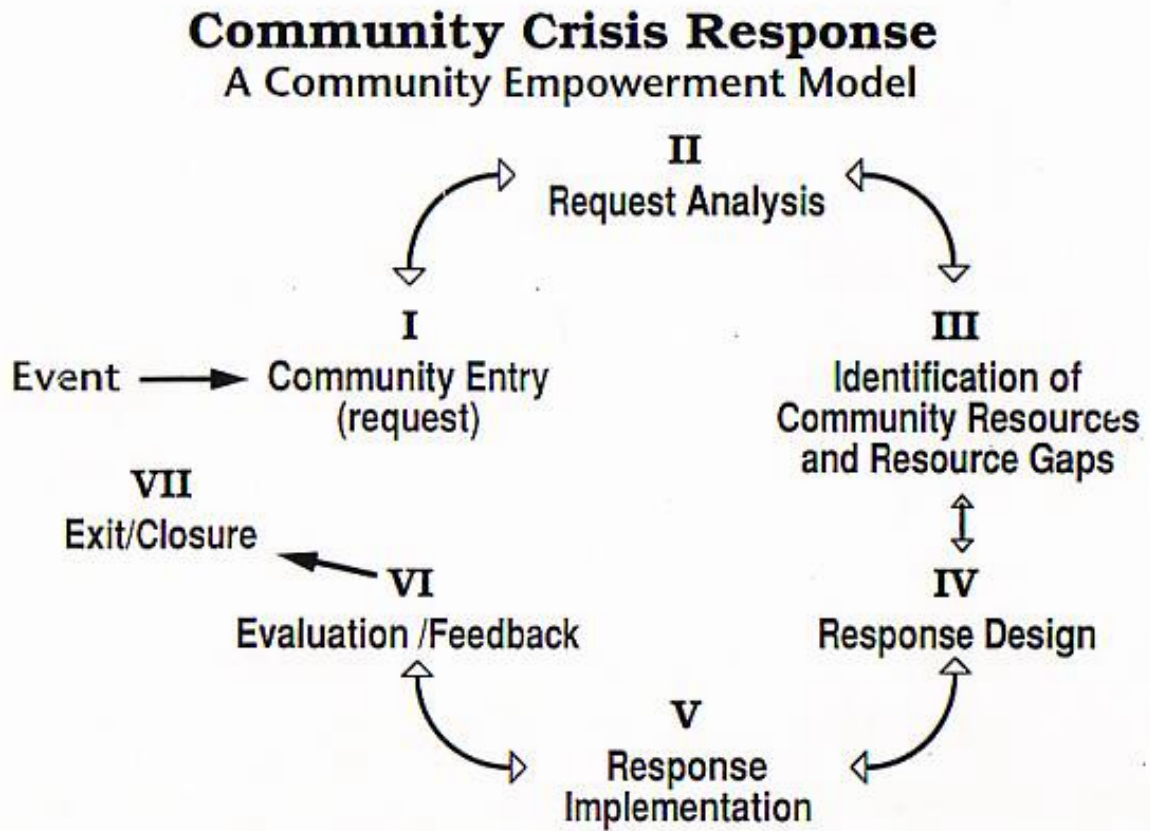
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Figure 1.

The Community Empowerment Model



Community Crisis Response Team- Victims of Violence Program, The Cambridge Hospital, MA

Footnotes

¹ This case typifies the kinds of events that prompt requests for CCRT assistance. Attributes of the case have been altered to ensure the anonymity of the victim, his family and his community.

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