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Exploring Community- and Society-Level Interventions for Healing Historical Trauma: A Grounded Theory Study

Anabel Mifsud
University of New Orleans, amifsud@uno.edu

Exploring Community- and Society-Level Interventions for Healing Historical Trauma: A Grounded Theory Study

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Anabel Mifsud

B.Psy. University of Malta, 2001
M.S. University College London & King's College London, 2011

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DEDICATION

To Darren for never leaving my side on this great adventure
and
to Vivian for having so much faith in me.

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This project, like many of life's great endeavors, would not have been possible without the support of many people who carried me through to the finish line.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS

ACA	American Counseling Association
ACEs	adverse childhood experiences
ACT	acceptance and commitment therapy
AHF	Aboriginal Healing Foundation
AIAN	American Indian and Alaskan Native
APA	American Psychiatric Association
CBT	cognitive behavior therapy
CBTs	cognitive behavior therapies
CDC	Centers for Disease Control and Prevention
CPT	cognitive processing therapy
CT	cognitive therapy
DBT	dialectical behavior therapy
DSM	*Diagnostic and Statistical Manual of Mental Disorders*
EMDR	eye movement desensitization and reprocessing
ET	exposure therapy
HPA	hypothalamic-pituitary-adrenal (axis)
IRB	institutional review board
ITTM	intergenerational trauma treatment model
MAOs	monoamine oxidase inhibitors
PE	prolonged exposure
PTSD	posttraumatic stress disorder
REBT	rational emotive behavior therapy
SAMHSA	Substance Abuse and Mental Health Services Administration
SNRIs	serotonin norepinephrine reuptake inhibitors
SSRIs	serotonin reuptake inhibitors
TCMI	trauma and the continuity of self: a multidimensional, multidisciplinary, integrative (framework)
TF-CBT	trauma-focused cognitive behavior therapy
THH	transforming historical harms (model)
TTHT	transgenerational transmission of historical trauma (model)
TTRG	transgenerational trauma and resilience genogram
WWI	World War I
WWII	World War II

ABSTRACT

Addressing historical trauma in populations that have been exposed to long-term mass violence, persecution, and systematic oppression is a critical step in the healing process in affected communities and societies. Despite the growing consensus for adopting a multilevel approach to mitigate the present-day impacts of historical grievances, extant literature on collective mental health interventions that address historical trauma is limited, fragmented, and largely theoretical. The purpose of this constructivist grounded theory study was to examine how mental health practitioners respond to the challenges of historical trauma at the community and society levels, and to explore the functions that professional counselors can assume in collective historical trauma interventions. Intensive interviews were conducted with 12 mental health practitioners who had firsthand experience delivering community-based and/or society-level mental health interventions for historical trauma.

The study shed light on six empowering processes that manifested across the various historical trauma interventions delivered by the participants. These empowering processes were: (a) holding the space; (b) naming the problematic; (c) revisiting history; (d) decolonizing trauma and healing; (e) mobilizing and building capacity; and (f) translating awareness, knowledge, and skills into action. Each of the six empowering processes seemed to promote mindful engagement by facilitating meaning in context and purposeful action. Mindful engagement seemed to enable people to transition from a state of disconnection to connection and eventually to action. All six empowering processes are consistent with the scope of practice and the knowledge and skills of mental health counselors. The implications of the findings for counselors and counselor educators and recommendations for future research are discussed.

Keywords: historical trauma, collective interventions, counselors, constructivist grounded theory

CHAPTER I

INTRODUCTION

In this chapter, I provide an overview of this grounded theory study on community- and society-level interventions that address the legacy of historical trauma. I start the chapter by examining the context of the study, which is followed by the problem statement. Next, I present the purpose and significance of the study, including the research questions and objectives that steered the investigation. A discussion of the theoretical framework that informed the inquiry and an overview of the research methods utilized in the study are included in the chapter. I also address the assumptions underlying the study and the limitations and delimitations. I conclude the chapter with the definitions of key terms used in this manuscript, a summary of the chapter, and a synopsis of the remaining chapters.

Context of the Study

As the world today becomes increasingly volatile due to rising civil unrest, political conflicts, and geopolitical tensions, mass violence is a significant threat to mental health and well-being more than ever. The Institute for Economics and Peace (2019) reported that two of the three domains represented by the global peace index, ongoing conflicts and safety and security, have registered a deterioration over the past decade. Although interstate conflicts have waned, there has been an upsurge in internal conflicts and terrorism, which contributed to the lower performance in the global peace index. The number of intrastate armed conflicts has been on an upward trend since 2010; in 2018 there were 52 armed conflicts (Strand et al., 2019) compared to 40 in 2014 and 31 in 2010 (Pettersson & Wallensteen, 2015). The number of conflict fatalities has increased by 140% between 2006 and 2017; the worst period recorded was between 2010 and 2014 at the height of the Syrian civil war when the death toll rose by 252%

(Institute for Economics and Peace, 2019). Additionally, conflicts are increasingly affecting civilians and the total number of non-combatant deaths has soared (Marshall & Elzinga-Marshall, 2017).

Aon (2019) issued a similar warning in their annual report on political risk, terrorism, and political violence. Based on data for 2018, Aon reported continued instability in most regions of the world, which poses a threat to both global and state order. This volatile atmosphere was attributed to the rise in authoritarianism and nationalism/populism, which have strained relationships among allies, fueled geopolitical rivalry, heightened the risk of regime instability, and undermined international multilateral institutions. Also, political violence is no longer confined to known politically unstable global zones. In Europe and North America, there has been an increase in terrorist attacks motivated by extreme right-wing ideology, which have nearly doubled in frequency since 2016 (Aon, 2019). In some societies, violent crime has replaced armed political conflict (The World Bank, 2011).

The World Bank (2011) noted that many of those who survive political conflicts in their country or region become caught in cycles of recurring violence, weak governance, and instability. Ninety percent of civil wars and internal conflicts in the last decade occurred in countries that had already experienced war in the previous three decades. It is safe to say that even in developed countries, political tensions reverberate longstanding hostilities that were never successfully reconciled. Recurrent violence is a major shared concern because of its potential to subvert global and regional peacebuilding, development, and prosperity (The World Bank, 2011). Against this backdrop, exploring ways to interrupt the vicious cycle of violence is an imperative to ensure sustainable peace.

Addressing the trauma resulting from long-term exposure to violence is a critical element in the healing process of post-conflict societies. Mass political violence causes collective trauma. Volkan (2009) suggested that specific mass traumatic events, which he termed chosen traumas, can become etched in the collective memory of the traumatized group or community, and may serve to incite future violence. Chosen traumas can fuel behavioral re-enactments at both the interpersonal and societal levels (Gobodo-Madikizela, 2008; Herman, 1997). Re-enactments can take many forms, such as child abuse, domestic violence, and societal strife.

The chances of transmitting trauma to the next generation become higher when individuals, families, and societies are unable to come to terms with their past trauma. The intergenerational transmission of trauma in cultures that have been subjected to harrowing acts of violence and oppression is also known as historical trauma (Brave Heart, 1998). In these situations, the trauma weaves itself into the fabric of the community or society for generations. Gampel (2000) paralleled the impact of mass violence to radioactivity to illustrate the legacy of the resultant trauma on future generations. Similarly, Volkan (2009) argued that chosen traumas can prevail for centuries. The transmission of historical trauma is insidious in that families, communities, and societies can become locked in destructive social patterns and relentless violence that cannot be singularly resolved by a ceasefire agreement or a peace treaty (Barsalou, 2005).

Individual trauma interventions can help survivors come to terms with their experience, reclaim their dignity and self-worth, and move on with their lives (Peace Building Initiative, 2009). However, individual interventions are insufficient to address the layered and collective nature of historical trauma. It is not feasible to work with all those whose lives have been collective touched by trauma (Hoffman & Kruczek, 2011), and individual interventions may not

be compatible with the values of collectivistic cultures (de Jong, 2011; Somasundaram, 2014). Additionally, trauma cannot be divorced from its ecological context, which means that the context needs to be rehabilitated too (Somasundaram, 2014; Sotero, 2006).

Today, there is a growing consensus on the need to design and deliver interventions at different systems levels to deal with collective types of trauma (Audergon, 2004; Evans-Campbell, 2008). Truth and reconciliation commissions, such as the ones in South Africa, Rwanda, and Guatemala, are just one example of collective interventions targeted to acknowledge suffering and trauma, while instituting political legitimacy (Moon, 2009). Mental health practitioners can implement and participate in different systemic interventions to redress the historical harms of mass violence and oppression, such as school- and community-based programs, sociotherapy, traditional healing methods, and social and political advocacy (Audergon, 2004; Brave Heart, 2003; de Jong, 2002; Scholte & Ager, 2014; Somasundaram, 2014). Collective interventions are critical to addressing the legacy of historical trauma and interrupt the perpetuation of violence and trauma. Their promise echoes the spirit of the opening statement of the preamble of the Charter of the United Nations: "We the peoples of the United Nations, determined to save succeeding generations from the scourge of war, which twice in our lifetime has brought untold sorrow to mankind" (U.N. Charter preamble, para. 1).

Problem Statement

The concept of historical trauma gained recognition in the fields of counseling and psychology in the 1960s through clinical studies with children of Holocaust survivors (Danieli, 1998; Dass-Brailsford, 2007; Kellermann, 2001c). Since then, historical trauma has become a conceptual lens for understanding the legacy of repressive regimes, slavery, human rights abuses, genocide, and war in different cultural groups (Adonis, 2016; Baker & Gippenreiter, 1998;

Barron & Abdallah, 2015; Brave Heart & DeBruyn, 1998; Daud et al., 2005; DeGruy, 2005; Ramos, 2013). Despite the flourishing interest in historical trauma across various disciplines, scholarship in this field is still not clearly situated within the broader trauma literature. Empirical evidence supporting the precise nature and manifestations of the phenomenon is limited (Brown-Rice, 2013; Evans-Campbell, 2008; Gone, 2009; Kirmayer et al., 2014; Sotero, 2006). Notwithstanding these challenges, there have been significant advancements in knowledge on the psychosocial effects and transmission mechanisms underlying historical trauma.

Several researchers attempted to elucidate how trauma is transmitted from one generation to the next. The intergenerational transmission of historical trauma thus far has been attributed to biological and epigenetic processes (Yehuda & Bierer, 2007; Yehuda & Lehrner, 2018; Youngson & Whitelaw, 2008); psychological mechanisms (Auerhahn & Laub, 1998; Barocas & Barocas, 1980; Rowland-Klein & Dunlop, 1998; Volkan, 1996); parenting, parent-child interactions, and family dynamics (Bar-on et al., 1998; Brave Heart, 1999b; Campbell & Evans-Campbell, 2011; Danieli, 1998; Kellermann, 2001c; Klein-Parker, 1988), and sociocultural processes (Brave Heart & DeBruyn, 1998; Chandler & Lalonde, 1998; Mohatt et al., 2014; Volkan, 1996, 1997, 2001, 2009; Wessells & Strang, 2006).

Other scholars have explored individual, family, and community responses to historical trauma. Although the bulk of the research in this area focused on individual and family symptoms, it is widely acknowledged that the impact of historical trauma can manifest itself and cause psychosocial distress at multiple levels, including the individual, family, and community levels (Evans-Campbell, 2008; Hoffman & Kruczek, 2011). Consequently, individual mental health interventions are necessary but insufficient unless combined with community- and

society-level interventions (Hoffmnan & Kruczek, 2011; Somasundaram, 2014; Wesley-Esquimaux & Smolewski, 2004).

Despite the need for more communal approaches to facilitate healing in groups affected by historical trauma, there is a paucity of empirical research on collective mental health interventions that target historical trauma (Evans-Campbell, 2008). Extant literature is fragmented and largely theoretical, at times taking the form of guidelines addressing post-conflict reconciliation, transitional justice, and peacebuilding. Also, scholarship in this area hails from numerous disciplines, such as anthropology, sociology, social work, and to some extent psychology, but only minimally from counseling. It is my belief that mental health counselors, by virtue of their professional training, can play a central role in designing and delivering collective historical trauma interventions. Their involvement in systemic interventions is consistent with the counselor's developmental domains articulated by the *Multicultural and Social Justice Counseling Competencies* (Ratts et al., 2015) and the *American Counseling Association Advocacy Competencies* (Toporek & Daniels, 2018). To this end, the purpose of the study was to shed light on how mental health practitioners respond to the challenges of historical trauma at the community and society levels and to explore the functions that professional counselors can assume in collective historical trauma interventions.

Purpose of the Study

The purpose of the study was two-pronged: (a) to investigate how mental health practitioners address historical trauma at the community and society levels, and (b) to explore the roles and functions that mental health counselors can assume in the delivery of collective historical trauma interventions. The bioecological model (Bronfenbrenner & Ceci, 1994) was used as a theoretical framework to contextualize the various systemic levels at which counselors

and other mental health practitioners can intervene to interrupt the intergenerational cycle of historical trauma from a collective perspective.

Research Questions

The study was guided by the following research questions:

- How do mental health practitioners address historical trauma at the community and society levels?
- What functions can mental health counselors assume in the delivery of collective historical trauma interventions?

Research Objectives

The research objectives informing the study were

- to explore different kinds of interventions undertaken by mental health practitioners to address historical trauma at the community and society levels;
- to examine the strengths and limitations of these collective interventions;
- to identify innovative mental health approaches that can be used to address historical trauma from a collective perspective;
- to uncover how the cultural and sociopolitical contexts influence how mental health practitioners conduct collective historical trauma interventions;
- to investigate how mental health practitioners engage with affected communities and populations when delivering collective historical trauma interventions;
- to explore how mental health practitioners interface with community leaders and professionals from other disciplines in the design and delivery of collective historical trauma interventions; and

- to examine the role that mental health counselors can play in the delivery of collective historical trauma interventions.

Significance of the Study

Despite the growing consensus on the need to adopt a multilevel, ecological approach to promote healing in populations affected by historical trauma, limited empirical research exists on collective interventions addressing historical trauma. The findings of the study illustrate how mental health practitioners address the phenomenon of historical trauma through a variety of community- and society-level interventions. The study results also shed light on the contribution that counselors can offer toward undoing the legacy of mass violence, oppression, and subjugation and promoting community and society healing.

Theoretical Framework

Although the bulk of psychological literature on trauma largely focuses on intrapsychic symptoms and individual interventions (Srinivasa, 2007; Wieling & Mittal, 2008), a shift in the conceptualization of trauma and trauma interventions has occurred over the past two decades (Goodman, 2013). Counselors and other mental health professionals, nowadays, are adopting a broader perspective on trauma by taking into account community and larger systemic variables (e.g. cultural, political, and socioeconomic factors) that have an impact on the individual experience of and recovery from trauma (Dass-Brailsford, 2007; Hoffman & Kruczek, 2011). As a result, social-ecological models have gained prominence in the field of trauma counseling and behavioral health services (Centers for Disease Control and Prevention [CDC], 2009; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

A social-ecological paradigm enables a more holistic and contextual understanding of trauma by considering environmental characteristics that exacerbate or buffer the impact of

trauma, as well as aspects that promote or inhibit resilience and recovery (Goodman & West-Olatunji, 2008; Harvey et al., 2003). This integrative framework offers a wide-angle lens for exploring the phenomenon of historical trauma. It also supports the notion of designing and implementing interventions that target community and societal elements that perpetuate historical trauma. For these reasons, I adopted the bioecological model by Bronfenbrenner and Ceci (1994) as the theoretical framework for the study. The bioecological model of development is one of the earliest socio-ecological models.

The Bioecological Model of Development

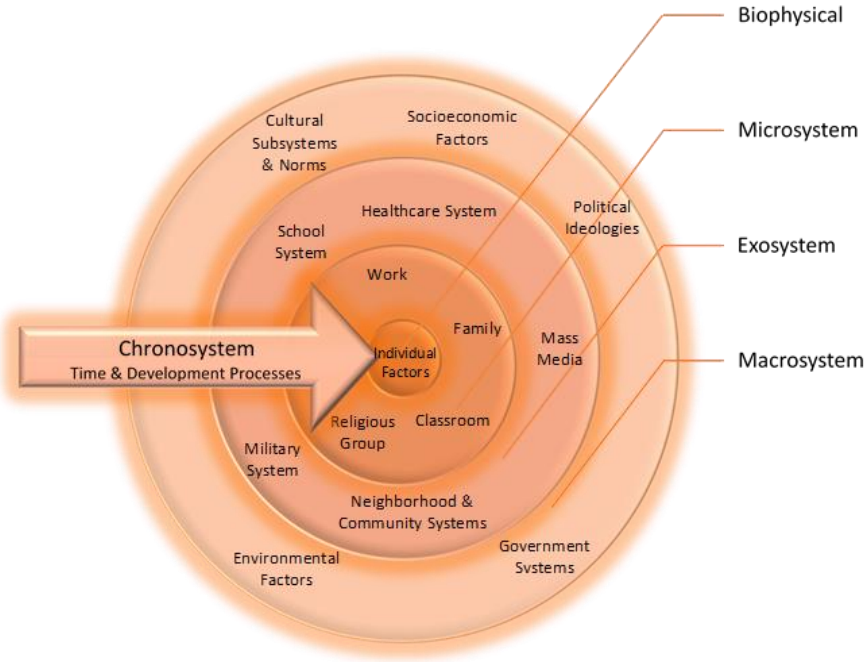
The bioecological model (Bronfenbrenner & Ceci, 1994) builds on the ecological systems model, originally proposed by Urie Bronfenbrenner (1977). The bioecological model posits that human development is a transactional and dynamic process that is influenced by the individual's environment as well as personal and biophysical characteristics.

According to the bioecological model, an individual's social environment consists of a number of nested systems that include the micro-, meso-, exo-, macro-, and chronosystems as shown in Figure 1. Interactions between an individual and the nested systems, as well as interactions among the systems, influence the impact of life events on that person's life as well as their response to these events. The individual with their unique biophysical and personality traits is situated at the center of the model. The microsystem represents the immediate settings inhabited by an individual, such as home, school, and work. The mesosystem illustrates the relationship between two or more microsystems, such as the relationship between home and the workplace; a mesosystem is a system of microsystems. The exosystem constitutes the environmental contexts that indirectly influence an individual's immediate settings, such as the relationship between a healthcare provider and home or the police and neighborhood. The

macrosystem symbolizes the overarching patterns of ideology, attitudes, and social organization in a particular culture or subculture, such as cultural norms and beliefs, and the economic, social, legal, and political systems. The macrosystem embodies the patterns in the micro-, meso-, and exosystems that characterize a given society or a section thereof. The chronosystem accounts for the influence of time on the interactions among the different systems within an individual's lifespan and across generations. The bioecological model offers not only a contextual understanding of human development; it also offers a multilevel framework that informs the delivery of behavioral health interventions across multiple systems to promote individual and collective healing and well-being.

Figure 1

The Bioecological Model of Development



Note: From "A bioecological model of mass trauma: Individual, community, and societal effects," by M. A. Hoffman and T. Kruczek, 2011, *The Counseling Psychologist*, *39*(8), p. 1090 (https://doi.org/10.1177/0011000010397932). Copyright 2011 by the American Psychological Association.

Applicability of the Model

All life events, including traumatic ones, happen within a context. The bioecological model has been proposed as a useful conceptual framework to understand the effects of individual and collective trauma (Hoffman & Kruczek, 2011; Stanciu & Rogers, 2011). The model was a good fit for the study primarily because it accounts for the proximate, distal, and temporal factors that shape the experiences of historical trauma. The bioecological systems model addresses the collective and broader aspect of historical trauma by considering interpersonal, community, institutional, socioeconomic, and political factors that influence how people are affected by and heal from historical trauma. Furthermore, because time is a key dimension in this model, it helps explain the cumulative nature of historical trauma, meaning the accrued emotional and psychological injury experienced over the lifespan and across generations.

The bioecological model is also congruent with the wellness perspective embraced by the counseling profession, with its focus on wellness instead of psychopathology (Hoffman & Kruczek, 2011). The bioecological perspective emphasizes not only environmental risk factors but also protective elements that encourage effective coping and resilience in response to trauma (Harvey, 2007). In fact, a common suggestion offered by trauma researchers is to develop supportive communities that promote resilience as part of trauma-informed interventions (Goodman & West-Olatunji, 2008). The model also favors the recognition of multicultural and social justice issues that influence the outcomes of trauma (Hoffman & Kruczek, 2011). As I will discuss in the next chapter, historical trauma is often perpetuated through institutionalized discrimination and oppression.

The bioecological model with its multilevel nested systems was a useful framework to conceptualize the multiple levels at which counselors and other mental health practitioners can intervene to address historical trauma across systems. In exploring how historical trauma can be addressed through community- and society-level interventions, the bioecological model served as a guide to determine which of the interventions delivered by mental health practitioners were of interest to the study, depending on which of the nested systems were targeted by the interventions. It also helped me identify potential participants for the study who had delivered collective trauma interventions at the systemic levels postulated by the model. Finally, the model was useful when I was identifying sensitizing concepts during data analysis.

Overview of the Methods

The study was situated within a constructivist theoretical orientation. Constructivism postulates that reality is socially constructed, meaning that how people make sense of themselves and the world around them is a product of their interactions with their social surroundings (Lincoln & Guba, 1985). Based on a constructivist research paradigm, I adopted a qualitative research design to answer the research questions and used constructivist grounded theory as the research methodology for the study (Charmaz, 2014). I collected data by means of intensive interviewing.

Qualitative research is useful for examining how people make sense of their social world and it generates thick descriptive accounts of the phenomena under study (Smith, 2008). This focus is consistent with the purpose of the study, which was to tease out the subjective meanings of mental health practitioners on how to redress the legacy of historical trauma in affected communities and populations by means of systemic interventions. A qualitative design

promoted a nuanced understanding of how participants construed their involvement in the delivery of interventions that addressed historical trauma at the community and society levels.

Grounded theory methods are designed to illuminate individual and social processes, and the interaction between individuals and their social context (Charmaz, 2014). A constructivist grounded theory methodology was used to uncover the meanings that mental health practitioners ascribed to historical trauma, collective interventions, and their unique professional role in historical trauma interventions, and how these understandings shaped their efforts to address historical trauma at the community and society levels. Additionally, grounded theory methods helped expose how mental health counselors negotiated meaning around their professional identity when delivering collective historical trauma interventions.

Research Participants

In a qualitative study, the researcher must identify suitable research participants who can shed light on the studied phenomenon and assist in answering the research question(s) (Merriam & Tisdell, 2016). In the present study, I explored the perspectives of various mental health practitioners, such as counselors, psychologists, psychiatrists, and social workers as well as non-mainstream practitioners, who have worked with populations affected by historical trauma, and who have delivered psychosocial interventions that address historical trauma at the community and society levels. The sample was composed of 12 participants. The sample size was determined through theoretical saturation.

Participants met the inclusion criteria set forth for the study, including: (a) have direct experience working with populations affected by historical trauma; and (b) have practical experience in delivering collective mental health interventions that address historical trauma at the community and/or society levels. The exclusion criteria of the study were lack of fluency in

the English language and not having access to the technology necessary to participate in an online interview.

Sampling and Recruitment

The sampling strategy for the study entailed initial sampling followed by theoretical sampling. In constructivist grounded theory, initial sampling enables the researcher to gain access to the data, whereas theoretical sampling provides direction to the research process (Charmaz, 2014). I applied initial sampling to identify potential participants who met the sampling criteria outlined above, and to start preliminary data gathering. Theoretical sampling informed the iterative process of moving back and forth between data collection and analysis. I implemented theoretical sampling to focus and streamline data collection and analysis for the purpose of developing and refining emerging theoretical categories and reaching theoretical saturation.

Prior to participant recruitment, permission for human subjects' research was sought from the University Committee for the Protection of Human Subjects in Research at the University of New Orleans. Next, a list of potential contributors who met the participation criteria of the study was compiled based on a thorough literature and internet search. Prospective participants were solicited via an email invitation to participate in the study.

Data Collection

Data collection was carried out by means of intensive, semi-structured interviews. Research participants were asked to participate in two one-on-one interviews: an initial interview and a follow-up interview. Intensive interviews allowed for an in-depth and open-ended examination of the participants' experiences and their social contexts (Charmaz, 2014). In grounded theory research, intensive interviewing serves as a tool to gather rich data about the

studied phenomenon and to advance theory development as the researcher cycles back and forth between data collection and analysis (Charmaz, 2014).

All the interviews were conducted online using videoconferencing technologies that permitted real-time, synchronous communication, namely Skype and Zoom. The use of online interviewing extended the reach of the study beyond the local geographical area. It also helped to increase the diversity of the study sample by recruiting mental health practitioners from different cultural backgrounds who would otherwise have been difficult to access because of geographical distribution and associated time and financial constraints. Interviews were audio-recorded and transcribed verbatim for data analysis purposes.

Data Analysis

I used the analytic coding procedures and methods pertaining to constructivist grounded theory. During initial coding, interview transcripts were examined line-by-line for a thorough and nuanced analysis of the data (Charmaz, 2014). Initial coding was followed by focused coding. Focused coding was used to streamline emerging analytical concepts and provide theoretical sensitivity to the analysis. I used theoretical coding to integrate the emergent categories and render coherence and theoretical direction to the analysis (Charmaz, 2014). Throughout the analysis, I applied comparative methods to discern similarities and nuances in the research participants' meanings, perspectives, and actions, and thus develop conceptually dense and robust categories. Additionally, memo-writing was used as an analytic tool to develop and refine emergent categories, and to organize and consolidate the analysis into a coherent theoretical product.

Assumptions of the Study

The study was based on two assumptions:

- Participants were knowledgeable about the topic of the study and thus able to provide rich data and an insightful contribution in line with the purpose of the study.
- Participants were honest and forthcoming about their knowledge and experience in delivering community-based and society-level historical trauma interventions.

Limitations and Delimitations

Limitations are shortcomings or constraints in the study design and findings over which the researcher has limited or no control (Leedy & Ormrod, 2016; Rudestam & Newton, 2015). The study had a number of limitations inherent to the type of data gathered, the research methods used, sample size, and the researcher. First, the use of qualitative data coupled with a small sample size limited the generalizability of the findings to different sociocultural contexts. The results of the study were rested on the subjective perspectives and experiences of the interviewed mental health practitioners who were situated in specific cultural settings, which limits the applicability of the final theoretical model beyond the cultural realities of the study participants. Further research is required to assess and determine the applicability and relevance of the generated theory across diverse populations affected by historical trauma.

The use of intensive interviewing as the exclusive source of data was another limitation. The credibility of the analytic categories and the final theoretical model could have been enhanced by applying triangulation, meaning the use of multiple methods to gather data. It was not possible to triangulate findings in the present study due to time and resource constraints.

In qualitative research, the researcher is the primary instrument of data collection and analysis, which is both a strength and a limitation (Merriam & Tisdell, 2016). The analysis and interpretation of the data is influenced by the researcher's assumptions, biases, and personal experiences. To account for this inherent constraint, I discuss my positionality as a researcher in Chapter III, including my frame of reference, preconceptions, theoretical orientation, and experiences relevant to the research topic. Given that I do not identify myself as a member of the cultural groups that were addressed by the study, my interpretations of the data were impacted by the lack of in-depth knowledge of the sociocultural, historical, and political factors that shaped the study participants' experiences and perspectives. I used member checking to mitigate this limitation and ensure that the conceptual categories were firmly grounded in the participants' cultural, historical, and political realities.

Delimitations are restrictions that the researcher imposes on the research design (Rudestam & Newton, 2015). The delimitations of the study were related to the conditions imposed by the sampling procedures and criteria. First, many of the mental health practitioners who were invited to participate in the study had their work and endeavors in the field of historical trauma published in scholarly journals or in the World Wide Web in the English language. Additionally, only mental health practitioners who were fluent in the English language were recruited in the study. Finally, only mental health practitioners who had access to the Internet and to the necessary hardware and software could participate in the study. These delimitations excluded mental health practitioners who did not meet the established criteria and procedures but nonetheless could have made a valuable contribution to the subject of the study.

Definition of Key Terms

The following key terms are used throughout the dissertation:

Collective interventions: Psychosocial interventions that are designed to address the collective impact of mass traumatic events and promote communal healing (Somasundaram, 2014). In the study, collective interventions were also referred to as systemic interventions and the two terms were used interchangeably.

Collective trauma: The adverse consequences of mass traumatic events at the collective level, including the disruption and damage to "social processes, networks, institutions, functions, dynamics, practices, capital, and resources, [and] the wounding and injury to the social fabric" (Somasundaram, 2014, p. 47).

Community-level interventions: Systemic trauma interventions that are based in the community and designed to enhance person-community relationships (Harvey, 1996).

Historical trauma effects: The multidimensional effects of historical trauma on individuals, families, communities, and societies in second generation survivors and successive generations (Evans-Campbell, 2008). In the study, historical trauma effects were also referred to as historical trauma impacts, historical trauma responses, or historical trauma manifestations. These terms were used interchangeably.

Historical trauma: The cumulative emotional and psychological wounding sustained by members of a group who share a common identity, affiliation, or situation, as a result of prolonged mass traumatic events, such as violent conflict, genocide, colonization, slavery, and repressive regimes, which continues to have an effect on successive generations (Brave Heart, 2003; Sotero, 2006)

Intergenerational transmission of trauma: The transmission of the effects of trauma from one generation to the next through various mechanisms or processes, including biological and epigenetic processes, intrapsychic mechanisms, parenting and socialization processes, family dynamics, parent-child interactions, and sociocultural processes (Kellermann, 2001c).

Mental health practitioners: In the present study, I adopted a broad definition of mental health practitioners to include mainstream licensed mental health professionals who had undergone traditional mental health training, and practitioners who did not identify as mainstream mental health professionals but had received training in trauma awareness and recovery and had extensive experience delivering behavioral health interventions.

Primary survivors: The initial survivors of systematic mass violence and repression, typically executed through four methods, including acute and chronic physical and psychological violence, economic destruction, cultural dispossession, and displacement or segregation (Sotero, 2006). In the study, primary survivors were collectively referred to as the primary generation(s).

Psychological trauma: The psychic injury caused by a single or multiple events or a situation that is perceived by a person "as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being" (SAMHSA, 2014, p. 7).

Second-generation survivors: The offspring of primary survivors of mass traumatic events.

Society-level interventions: Systemic interventions that target societal structures and institutions (e.g. the educational and health care system) to promote social and political transformations that support healing, social justice, and sustainable peace.

Systemic interventions: Interventions that adopt a holistic, ecological approach to trauma and target one or multiple systems in the community and society (e.g. families and schools).

Systemic interventions are strengths-focused and strive to facilitate healing, promote resilience, and mobilize individual, family, community, and societal resources for sustained physical, emotional, psychological, spiritual, and communal healing (Landau et al., 2008).

Trauma-informed care: An intervention and an institutional approach that systematically attends to how trauma affects people's lives as well as their responses to behavioral health services all the way from prevention through treatment (SAMHSA, 2014). A trauma-informed approach incorporates three key elements: (1) *realizing* the prevalence of trauma; (2) *recognizing* how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) *responding* by putting this knowledge into practice (SAMHSA, 2014).

Chapter Summary and Organization of the Study

In this chapter, I provided an outline of the study, including the context of the research, the purpose and significance of the study, the conceptual framework informing the investigation, and the research methods that were used. The chapter also addressed the assumptions of the study, the limitations and delimitations, and the definition of key terms.

In Chapter II, I offer an in-depth review and analysis of the literature on the historical trauma, including a brief history of the concept of psychological trauma and an examination of the concepts of collective and cultural trauma and their relationship to the phenomenon of historical trauma. Next, the literature on historical trauma is discussed, including the different mechanisms underlying the intergenerational transmission of historical trauma; the multilevel impacts of historical trauma on second and subsequent generations; and various individual, family, and collective interventions to mitigate the pervasive consequences of historical trauma.

Chapter II concludes with an examination of community- and society-level interventions that facilitate the healing of historical trauma, including gaps in extant literature.

In Chapter III, I review the research questions and objectives and provide a detailed description of the study design, research methodology, sampling strategy, and participant recruitment procedures, as well as the rationale for all methodological choices. In this chapter, I also discuss my role as the researcher in the study, including my frame of reference, assumptions, theoretical orientation, and experiences relevant to the research topic. The chapter concludes with an overview of the measures that were undertaken to ascertain rigor and trustworthiness of the study results and the ethical considerations.

In Chapter IV, I introduce the study participants using detailed profiles. I also provide a step-by-step explanation of how I arrived at the conceptual categories and the final theoretical model. Next, I present the findings of the study. Participants' verbatim quotations from the interview transcripts are included to illustrate the study results and my interpretations of the data. The chapter concludes with a summary of the results.

In Chapter V, I first review the philosophical underpinnings of the study. Next, I analyze the findings of the study in relation to the research question and relevant extant literature. The implications of the findings for counselors, the counseling profession, and counselor educators are examined. Recommendations for future research, the limitations of the study, and my personal reflections are also included in this final chapter.

CHAPTER II

REVIEW OF THE LITERATURE

This literature review focuses on the phenomenon of historical trauma; its multilayered impact on individuals, families, and communities; and the application of multilevel interventions to redress the legacy of trauma in affected populations. In the first section of the chapter, a brief history of the concept of psychological trauma and a discussion of its limitations to account for collective experiences of trauma are offered. The concepts of collective and cultural trauma and their affinity to the phenomenon of historical trauma are examined next. The literature on historical trauma is reviewed, including the proposed mechanisms underlying the intergenerational transmission of trauma and the lingering effects of historical trauma on subsequent generations at the individual, family, and community levels. In the concluding section, a discussion of individual, family, and collective interventions to mitigate the pervasive impacts of historical trauma from extending to future generations is presented.

Psychological Trauma

The term "trauma" has its roots in the ancient Greek language, and it originally denoted a "wound" resulting from a physical injury (Dass-Brailsford, 2007). In the late 19th century, the meaning of the word "trauma" was broadened to describe a psychic wound inflicted by a devastating experience. Over time, the concept of trauma evolved into a metaphor that has become embedded in various professional discourses including those in psychology, sociology, anthropology, and politics (Levy & Sznaider, 2006). In addition to its medical connotations, the term "trauma" is now used to illustrate injuries to the psyche, spirit, communities, and societies. In the next section, the evolution of the concept of psychic trauma is discussed.

Historical Overview

Historically, accounts of posttraumatic responses in civilian and military populations can be traced back as far as the Great Fire of London in 1666 (Pepys, 1997) and the American Civil War (Lasiuk & Hegadoren, 2006). The expressions "soldier's heart" and "nostalgia" were used to describe the psychological effects of battle on soldiers. It was only in the late 19th century, however, that the notion of psychic trauma surfaced in psychological writings.

The Birth of the Concept of Psychological Trauma

The concept of psychological trauma first emerged in public discourse in the 1870s when the French neurologist Charcot was investigating the symptoms manifested by women who had endured sexual violence (Herman, 1997). Most of the women were diagnosed with hysteria, which Charcot referred to as "traumatic neurosis," a disorder that resembled neurological impairment because of its symptoms of motor paralysis, sensory loss, convulsions, and intermittent amnesia. Around 1880, Charcot was the first to establish the psychogenic origin of the hysterical symptoms of the female patients as he found that the symptoms could be artificially induced and abrogated through hypnosis.

Charcot's work on hysteria was later pursued by Janet in France, as well as Freud and his mentor Breuer in Vienna (Herman, 1997). In the 1890s, both Janet and Freud independently uncovered the association between the hysterical symptoms and the psychological trauma sustained by the female patients. They discovered that distressing events triggered an altered state of consciousness in the patients, which Janet termed dissociation and Freud and Breuer called double consciousness (Herman, 1997). Both Janet and Freud argued that the somatic symptoms of hysteria could be alleviated by recovering the banished memories of the traumatic experience and the intense feelings associated with them, and voicing them in a

therapeutic setting. This technique established the foundation of modern psychotherapy. Janet called this treatment method psychological analysis, whereas Freud and Breuer referred to it as abreaction or catharsis. Freud eventually coined the term psychoanalysis.

Whereas Janet stuck to his original line of inquiry as regards the psychological nature of hysteric symptoms and dissociation, Freud's efforts took a different turn. Freud's examination of his patients' symptoms led him to believe that childhood sexual exploitation was at the root of the patients' hysteria and to uncover the pervasiveness of sexual violations against children and women in Viennese society (Herman, 1997). Freud, concerned about the social and financial backlash from his supporters if he were to persevere with these findings, turned his attention to the patients' intrapsychic conflicts. He suggested that the hysterical symptoms stemmed from the women's unacceptable sexual and aggressive fantasies (seduction theory) rather than from actual sexual offenses. Freud's recantation of his earlier findings not only interrupted prematurely the study of psychological trauma, but it also relegated the brutality endured by women to obscurity.

The First and Second World Wars and the Vietnam War

Public discourse on psychological trauma resurfaced in the wake of the devastation brought about by World War I (WWI) and intensified right after the Vietnam War. Psychiatrists labeled the symptoms of WWI soldiers returning from the trenches as "shell shock," which they initially attributed to the soldiers' reactions to blast of the explosives (Benedek & Ursano, 2009). These symptoms included incontrollable weeping and screaming, paralysis, unresponsiveness, and memory loss. Psychological first aid was introduced to help soldiers recover from their symptoms so that they could return to the front without delay (Herman, 1997). Military psychiatrist eventually acknowledged that that symptoms presented by the soldiers were due to

the psychological trauma caused by the exposure to the atrocities of war, which they defined as "combat neurosis." The symptoms were nonetheless blamed on the soldiers' weak or inferior moral constitution. In World War II (WWII), military recruits who displayed this "character weakness" during screening were not allowed to join military service (Herman, 1997; SAMHSA, 2014).

The advent of the Second World War renewed interest in the understanding and treatment of combat neurosis or what became known as battle fatigue (Trimble, 1985). Treatment innovations were geared toward expediting the soldiers' return to the battlefield. Some soldiers were treated for battle fatigue by being prescribed to rest before returning to the battlefront (SAMHSA, 2014). Hypnosis or sodium amytal (a drug with sedative-hypnotic properties) were utilized as brief interventions to facilitate the retrieval and catharsis of traumatic memories (Herman, 2007). Although these latter interventions were regarded as successful at the time owing to the short period it took soldiers to return to active duty, neither of the techniques could redress the indelible effects of war trauma. In the United States (U.S.), the U.S. Army introduced group stress debriefing, although the primary purpose of this intervention was to gather actual facts and firsthand accounts of combat events from surviving soldiers in a supportive environment (Kaplan et al., 2001; Shalev et al., 1998).

By WWII the concept of post-trauma syndrome had started to take shape, paving the way to what today is known as posttraumatic stress disorder (PTSD) (Dass-Brailsford, 2007). The work of American psychiatrist Kardiner (1941/2012), who had treated U.S. war veterans of WWI, established the clinical features of traumatic neurosis, which included irritability, outbursts of aggression, an exaggerated startle response, and rumination on the traumatic events. Kardiner (1941/2012) attempted to normalize the traumatic symptoms displayed by soldiers by

arguing that they were a normal response to the horrors of war. After World War II, studies on the effects of prolonged stress on concentration camp survivors yielded findings similar to the observations with soldiers suffering from combat stress (Krystal, 1978). Systematic, large-scale inquiry into the lasting psychological repercussions of combat did not take off until after the Vietnam War, however (Herman, 1997).

During the Vietnam War, soldiers and veterans were returning with debilitating symptoms that often interfered with their reintegration into civilian life. In 1970, at the height of the Vietnam War, two psychiatrists, Lifton and Shatan, started conducting rap groups with Vietnam veterans who were affiliated with the new organization called Vietnam Veterans Against the War (Herman, 1997). During these meetings, Vietnam veterans shared their war experiences with their fellow veterans. The purpose of rap groups was two-pronged: to offer relief and support to Vietnam veterans affected by psychological trauma, and to raise public awareness about consequences of war. Lifton and Shatan (Lifton, 1973) catalogued 27 common symptoms of traumatic neurosis, based on their observations of Vietnam veterans and the findings of Kardiner (1941/2012) and other clinicians who worked with Holocaust survivors and victims of accidents. Later, their work informed the formulation of the diagnosis of PTSD for inclusion in the third edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) (van der Kolk et al., 1996). As rap groups grew in popularity and with increased political pressure from veterans' organizations, the Veterans Administration (now the U.S. Department of Veterans Affairs) launched Operation Outreach which resulted in the opening of over 100 outreach centers across the U.S. These centers were run by veterans for veterans (Herman, 1997). The sustained social and political advocacy by veterans also opened the door to systematic inquiry into the psychological legacy of

war on returning veterans. Empirical research on psychological trauma burgeoned during the post-Vietnam era.

The Women's Liberation Movement

At the same time that psychological trauma gained public recognition through the experiences and efforts of combat veterans, the Women's Liberation Movement of the 1970s brought to the forefront the deleterious effects of interpersonal violence on the lives of women (Herman, 1997). The Women's Liberation Movement exposed the pervasiveness of domestic and sexual exploitation of women, echoing the same social reality that was revealed by the studies on hysteria in the late nineteenth century but later dismissed by Freud as sexual fantasies. Feminist activists like Friedan and Brownmiller drew attention to the fact that interpersonal violence against women was the most common cause of psychological trauma, far more common than war (Herman, 1997). Sarachild and other feminists introduced consciousness-raising groups that bore resemblance to the veterans' rap groups. The groups offered women a safe space to share their stories and to receive validation and support. These groups also provided the impetus to demand social and institutional changes. The plight of survivors of rape began to be heard and in 1971 the first crisis rape center was established (Herman, 1997).

By the mid-1970s, reforms to legislation governing rape were under way and the National Institute of Mental Health instituted the Center for Research on Rape (Herman, 1997). During this time, research on rape, domestic violence, and childhood sexual abuse proliferated and researchers noted that the victims' psychological responses resembled those reported by combat veterans. Burgess and Holmstrom (1974), who investigated the psychological effects of rape, called the survivors' symptoms rape trauma syndrome, and Walker (1979) coined the term battered woman syndrome to describe the psychological reactions of women exposed to

domestic violence. It was only in the 1980s, following the recognition of PTSD as a formal diagnosis by the American Psychiatric Association, that the psychological sequelae of rape, domestic battery, and childhood sexual abuse were recognized to be identical to the symptoms witnessed in combat veterans (Herman, 1997).

Psychological Trauma and the DSM

PTSD was incorporated into the DSM-III in 1980 in recognition of the severe and long-term psychological symptoms presented by Vietnam veterans (Ringel, 2012). Advocates for combat veterans as well as supporters of survivors of rape, domestic violence, and child abuse lobbied with DSM-III committees to legitimize PTSD as a diagnostic entity (van der Kolk et. al., 1996). In the DSM-III (APA, 1980), PTSD was classified as an anxiety disorder and the gamut of behavioral, cognitive, and emotional reactions were grouped under three categories: intrusive re-experiencing, persistent avoidance or numbing, and hyperarousal/hypervigilance. The inclusion of PTSD in the DSM-III inspired a growing body of research, including clinical, epidemiological, and neurobiological studies (Dass-Brailsford, 2007).

In the DSM-III (APA, 1980), the traumatic event constituted "a catastrophic stressor that is outside the range of human experience" (p. 236), thus differentiating it from stressful situations that are part of the ordinary vicissitudes of life, such as life-threatening illness, relationship breakups, or financial reverses. This constricted definition of traumatic experience led to a controversy on the nature of trauma, namely because the presence of a precipitating stressor is one of the criteria for the diagnosis of PTSD (Friedman, 2019; SAMHSA, 2014). Unlike other psychiatric diagnoses, the ethological agent is inherent to nosological classification of PTSD.

The parameters that define a traumatic stressor were expanded in DSM-IV (APA, 1994) to include "an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" so long as "the person's response involved intense fear, helplessness, or horror" (p. 427). The diagnostic criteria for PTSD in this iteration included a history of exposure to a traumatic incident together with symptoms from each of three symptom clusters: intrusive recollections, avoidance or numbing behaviors, and hyperarousal. In addition, symptoms must have persisted for at least one month, and they must have caused major distress or functional impairment.

Empirical research and clinical trials influenced the revisions made to the fifth edition of the DSM (APA, 2013). The DSM-V has made considerable changes to the nosology and diagnostic criteria of PTSD that have significant conceptual and clinical implications (Friedman, 2019). One of the most notable changes is the classification of PTSD under a new category, Trauma- and Stressor-Related Disorders, instead of under the category of Anxiety Disorders. The insertion of a new category emphasizes the etiological basis of PTSD and other stressor-related disorders; all diagnoses under this category are preceded by a traumatic or adverse event(s) in the person's environment. Additionally, a new symptom cluster that encompasses negative cognitions and mood states was included. Reckless and self-destructive behaviors were added to the alterations in arousal and hyperactivity symptom cluster. Although the DSM-V has retained the broadened interpretation of a traumatic event outlined in the DSM-IV, in the latest iteration exposure to the traumatic event(s) has to be clearly qualified as either direct, witnessed, indirect, or repeated, indirect exposure (APA, 2013). Also, the criterion specifying that the person's initial response to the trauma must be characterized by intense fear, helplessness, or

horror was removed from the DSM-V, thus enabling a diagnosis of PTSD to be made independent of the emotional response of an individual.

The incorporation of trauma and PTSD in the DSM marked an important milestone in the understanding of psychological trauma. However, the delineations of trauma and PTSD continue to generate controversy around their applicability to specific traumatized populations, such as survivors of prolonged, repeated interpersonal violence, and traumatized individuals from non-Western countries and cultural settings (Friedman, 2019).

Today, trauma is no longer regarded as an abnormal experience. Several studies in the United States, such as the National Epidemiological Study (Kessler et al., 1999), confirmed the widespread prevalence of trauma in the general population. Over 60% of men and 51% of women reported experiencing at least one traumatic incident in their lifetime. Furthermore, the September 11, 2011 attacks as well as other acts of terror; the lengthy violent conflicts in Iraq, Afghanistan, Syria, and other countries; the sexual abuse scandals; the multiple school shootings; and the many natural disasters that have ravaged the livelihoods of entire communities across the globe have garnered the subject of trauma a central place in the public discourse. Over the past two decades, researchers have progressively attempted to discern the connections among trauma, psychological distress, mental and physical health, and substance abuse (SAMHSA, 2014). Studies such as the Adverse Childhood Experiences (CDC, 2019) and Women, Co-Occurring Disorders, and Violence (SAMHSA, 2007) exposed the long-lasting impact of childhood sexual abuse and domestic violence. Trauma research has also extended its scope to investigate other conditions like traumatic brain injury and serious orthopedic injuries (Starr et al., 2004).

The New Era of Trauma-Informed Care

Renewed public and scientific interest in trauma has ushered in a new era of trauma-informed care. The consumer movement in health care with its appeal for patient rights, federal agencies such as SAMHSA, and various national organizations have petitioned for trauma-informed care and policies. Trauma-informed care is both an intervention and an institutional approach that systematically attends to how trauma affects people's lives as well as their responses to behavioral health services along the range from prevention through treatment (SAMHSA, 2014). Trauma-informed care calls for a shift in how trauma is conceptualized, in which symptoms are perceived as adaptations to the traumatic stressor and resilience is emphasized over pathology. In the United States, the National Center for Trauma-Informed Care was established in 2005 to develop a comprehensive framework to assist health care systems to adopt trauma-informed practices and improve public behavioral health services and programs for trauma survivors.

Contemporary Conceptualizations of Trauma

The DSM-V ascribes trauma to a person's direct or indirect exposure to an event involving actual or threatened death or injury, or a threat to the physical integrity of oneself or others that begets a constellation of psychosocial symptoms (APA, 2013). However, the conceptualization of psychological trauma is not restricted to the diagnostic boundaries of PTSD in the DSM. The literature abounds with diverse characterizations of psychological trauma that have flourished throughout the years as mental health professionals wrestled with the essence of trauma. Although it is not purpose of this section to document all the different definitions and theoretical explanation attributed to psychological trauma, several salient definitions are briefly explained.

SAMHSA's Trauma and Justice Strategic Initiative described psychological trauma as the consequence of "an event, series of events, or set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2014, p. 7). SAMHSA's definition of trauma is similar to the DSM's depiction of trauma in that it focuses on the nature of the traumatic event(s) and the resultant fear and vulnerability, as well as the functional impairment in different domains of an individual's life.

Some trauma scholars have defined psychological trauma more broadly and have focused more on the interplay between the individual and the traumatic event. For example, Horowitz (1989) characterized psychological trauma as a sudden and threatening event that overwhelms a person's cognitive capacities, suggesting that traumatic experiences do not have to constitute a life threat or injury; they can pose a threat to psychological integrity. This definition also emphasizes the individual's inability to cognitively process the trauma-related information and integrate it with existing mental structures. In a similar vein, Janoff-Bulman (1992) depicted trauma as the shattering of an individual's assumptive world. She argued that traumatic events challenge three fundamental assumptions about the self, the world, and other people: (a) the belief that the world and people are benevolent; (b) the assumption that the world is meaningful, orderly, and logical; and (c) the belief that the self is worthy.

Another prominent definition of trauma was proposed by Herman (1997) who described trauma as "an affiliation of the powerless" (p. 33). She explained that traumatic events are extraordinary, not because they are atypical occurrences, but by virtue of their potential to render people helpless because they stun natural human adjustment. Herman's emphasis on helplessness is echoed by Spiegel (2006, 2008), who defined psychological trauma as a loss of

control over one's body and psyche, including loss of identity, conscious awareness, and memory that can result in dissociation.

In contrast, Turnbull (1998) considered traumatic responses as ordinary "adaptive mental processes involved in the assimilation and integration of new information with intense survival emphasis" (p. 88) that can become pathological only if inhibited or left untreated. Turnbull's perspective on trauma moves further away from the traditional pathological view of the phenomenon. Traumatic responses are instead perceived as part of the human survival instinct.

Trauma is indiscriminate because it can disrupt the lives of people of every race, ethnicity, gender, sexual orientation, socioeconomic status, and geographical region. Additionally, individuals can suffer psychological trauma at any age or developmental stage, with events that do not follow the expected life course, such as the death of a child or premature retirement because of illness, being more likely to be perceived as traumatic. Today, most psychological trauma researchers agree that it is not only the nature of an event that determines whether it is traumatic, but more so the individual's perception and interpretation of the event. This sentiment is reflected in phrases like "perceived life-threatening or overwhelming experiences" (Levine, 2005, p. 7) or "the meaning people attach to these events" (van der Kolk & McFarlane, 1996, p. 6). Nonetheless, certain events, especially those involving acts of violence, tend to trigger traumatic responses in most people (Friedman, 2019).

Major Types of Traumatic Incidents

Trauma scholars distinguish between different types of traumatic incidents. A traumatic experience can consist of a single event, a series of events, and/or a chronic condition as in the case of domestic violence or child neglect (SAMHSA, 2014). Traumatic events can be the product of nature, for example hurricanes, earthquakes, and landslides, or human-perpetrated,

such as physical assault, transportation accidents, and political violence. Human-caused traumatic events can be either unintentional, due to human negligence or error, such as motor vehicle and industrial accidents, or intentional such as rape or torture.

Certain traumatic events have the potential to overwhelm not only individuals but also families, communities, and at times societies at large. When events such as natural disasters and war cause profound disruption to large numbers of people, these experiences are thought to contribute to mass trauma (SAMHSA, 2014). It is not uncommon that mass traumatic events spawn secondary traumas and stressful circumstances such as obtaining basic needs or access to safe water supplies that further undermine coping and adjustment among survivors. As in the case of individual trauma, large-scale traumatic incidents can severely compromise or defeat the traditional resources of families, communities, and even societies (Hoffman & Kruczek, 2011). In these situations, the psychological trauma is not only experienced by individuals; it is shared by the collectivity, thus becoming a collective trauma. In the next section, I explore and discuss the interrelated concepts of collective and cultural traumas.

Collective and Cultural Traumas

The bulk of the psychological literature on trauma revolves around individual intrapsychic responses to traumatic experiences, even when the impact of mass traumatic events is under scrutiny (e.g. Srinivasa, 2007), thereby overlooking the effects at the collective level. This lack of interest in the collective aspects of trauma reflects in part the medicalized and individualized orientation adopted by Western mental health specialists (de Jong, 2004). Several trauma scholars, however, have recently started to acknowledge that trauma is a collective phenomenon as much as it is an individual experience (Audergon, 2004; Somasundaram, 2014). Consequently, there has been a growing interest in the psychosocial impact of disasters and

large-scale traumatic events at multiple system levels. Some trauma researchers drew attention to the need to consider family (Landau & Saul, 2004; Ager, 2006) and cultural dimensions (de Jong, 2002, 2004; Miller & Rasco, 2004; Silvore & Steel, 2006) in the wake of catastrophic events.

Various scholars supported their claims for the need to move beyond individual manifestations of trauma by underscoring how current conceptualizations of trauma and PTSD fall short of capturing and justifying the far-reaching ramifications of large-scale traumatic incidents on families, communities, and culture (de Jong, 2004; Drožđek, 2007; Somasundaram, 2014; Weichelt & Gryczynski, 2012). Trauma researchers have also argued that an individual focus is antithetical to non-Western collectivist values and beliefs that promote a more socio-centric understanding of the self (de Jong, 2004, 2011; Hoshmand, 2007; Wilson, 2007). Their assertions echo earlier observations made by Kleinman, Das, and Lock (1997) who suggested that societies, communities, and cultures shape how their members make sense of traumatic experiences through social and cultural representations of loss, suffering, and distress, and shifts in social processes and dynamics.

The prevailing impetus to explore collective responses to traumatic events is gradually permeating the field of trauma care (e.g. SAMHSA, 2014). A number of trauma experts have argued that a therapeutic focus that solely targets individual symptoms is inadequate (de Jong, 2002, 2004; Hoffman & Kruczek, 2011; Somasundaram, 2011, 2014) and in turn have advocated for an orientation that addresses the "personal, communal, and political" (Audergon, 2004, p. 16).

Collective Trauma

Somasundaram (2014) defined collective trauma as the negative consequences of mass traumatic events at the collective level, meaning the disruption and damage to "social processes, networks, institutions, functions, dynamics, practices, capital, and resources, [and] the wounding and injury to the social fabric" (p. 47). The subsequent maladaptive social transformations are the scars of collective trauma. In communities that have witnessed atrocities and extensive loss and destruction, the trauma becomes lodged in the social fabric of the community (Audergon, 2004).

Despite the budding interest in collective trauma in psychological literature, the concept has its roots in the field of sociology and anthropology. The original use of the concept in its contemporary application can be traced back to the seminal book *Everything in Its Path: Destruction of Community in the Buffalo Creek Flood* by the sociologist Kai Erikson (1976) who chronicled the aftermath of the devastating flood in Buffalo Creek, West Virginia in 1972. The flood shattered the way of life and structure of a tightly knit Appalachian community of 5,000 people. Erikson (1976) argued that the disaster resulted in a collective trauma that was more enduring than the individual traumas. He attributed the collective trauma to the erosion of social ties, the "loss of communality" (Erikson, 1976, p. 134), and the rupture in the social tissue of the community. Erikson also reported that the loss of communality resulted in disorientation, demoralization, apathy, weakened morality, escalating crime, and the dissolution of the entire community.

Similar explanations were advanced by the anthropologists, psychologists, and psychoanalysts who contributed to the distinctive collection of essays *Cultures under Siege: Collective Violence and Trauma* (Robben & Suárez-Orozco, 2000a). The authors engaged in an

interdisciplinary discussion on the nature of collective trauma within the context of political violence. Some of the contributors argued that large-scale violence and terror shatter the social order and safety inherent to a community or society, and subvert people's trust in the social institutions and cultural systems that confer structure and meaning to human life (Robben & Suárez-Orozco, 2000b).

Along the same lines, Giesen (2001) discussed social trauma, which he defined as a collective response to an event that undermines the social order and collective identity of a community. Giesen maintained that the traumatic memories of an event reside at the individual and collective levels, and that the two kinds of memories do not exist discretely. The sharing of individual traumatic experiences in a community has the potential to create a new sense of collective identity that over time enables the development of social trauma. At some point, the emerging social trauma comes to represent the collective suffering of a community and assumes a life of its own independent from the individual traumatic experiences (Geisen, 2001). From this perspective, direct exposure to the traumatic incident is not necessary for the community members to be affected by social trauma.

Social trauma is similar to collective trauma in that it is marked by shared mistrust, apathy, and disorientation brought about by the sudden collapse of legitimate social expectations and a damaged social structure. According to Giesen (2001), the social consequences of social trauma are decreased civic engagement, stagnation in economic development, and escalation in crime rates, which correspond to the tragic outcomes reported by Erikson (1976) in Buffalo Creek. The concept of social trauma underscores the loss of individual and collective identities due to the loss of the "culturally generated web of meaning" (p. 14474), and hence it intersects with the definition of cultural trauma.

Cultural Trauma

The concept of cultural trauma overlaps with the notion of collective trauma insofar as it embodies the social sequelae to mass traumatic events at the collective level. Unlike collective trauma, however, cultural trauma is based on membership in a specific cultural group and emphasizes the threat to collective identity and the role of collective memory. The concept of cultural trauma is complex, and its components have been discussed in disparate ways in the literature (Stamm et al., 2004). Several theoretical perspectives exist on cultural trauma, but for the purpose of this literature review, I limit myself to discussing the most prominent conceptualizations.

Alexander (2004) depicted cultural trauma as the irreversible effects generated by a significant event(s) that disrupts the cultural meaning-system of a group, made up of beliefs, values, norms, and knowledge. The traumatic event irrevocably tarnishes the group's consciousness and memories and alters its future identity. Alexander explained that cultural trauma necessitates a publicly accepted memory of an event or situation that is charged with negative emotions, and which is regarded as indelible and violating the group's existence or its fundamental cultural assumptions. Alexander (2004) posited that the traumatic event alone does not contribute to cultural trauma. Instead, it is the social meaning ascribed to the event and the socialization of its cultural members to the trauma that gives rise to the phenomenon. In other words, the cultural trauma process exists between the event and its representation. Consequently, cultural trauma is strongly influenced by the prevailing sociocultural context at the time of the traumatic event.

Similarly, Eyerman (2001) characterized cultural trauma as a "dramatic loss of identity and meaning, a tear in the social fabric, affecting a group of people that has achieved some

degree of cohesion" (p. 2), in his discussion of the lasting effects of slavery on the collective identity of African Americans. According to Eyerman, the memories and representations of slavery penetrated the consciousness of African Americans in the United Sates including individuals who neither experienced slavery directly nor had ancestors who did. Indeed, both Eyerman (2001) and Alexander (2004) insisted that direct exposure to the traumatic event is not necessary to experience the cultural trauma. Eyerman (2001) argued that collective memories have the capacity to trigger traumatic responses in the same manner as personal memories derived from first-hand experiencing of the traumatic event.

Alexander (2004) suggested that "cultural carriers" within the affected group, which he labelled as the carrier group, serve as the collective agents or social mediators of the trauma. Their role is to make public claims about the traumatic injury suffered by the carrier group and the resulting cultural damage and loss. Their assertions are intended to mobilize the carrier group to acknowledge and make sense of the traumatizing event, which supports the creation of cultural trauma. In time, trauma claims are extended to the larger social community. The social act of signification of trauma is intended to engender solidarity among survivors and facilitate the re-creation of a collective identity that incorporates the shared traumatic past. Over time, public trauma discourse is replaced by commemorations (memorial sites, museum exhibits) that honor public collective memory.

On the other hand, how societal institutions respond to the group's public claims of trauma, whether they are silenced or promoted, as well as the uneven distribution of power among social players, shape how the trauma becomes represented in a culture (Alexander, 2004). If major social institutions reject or stifle trauma claims or if the carrier group does not have access to resources to publicize its claims, the process of restoration and healing for the affected

group is stymied. Alexander's argument is consistent with the explanation posited by Wiechelt and Gryczynski (2012), who argued that the experience of cultural trauma is determined by the type of narrative constructed by the group members as well as the degree to which the narrative is recognized and accepted by society at large.

Sztompka (2000) suggested that cultural trauma happens within a context of cultural disorientation caused by radical and unexpected technological, economic, and political disruptions; his definition accounts for events like political assassinations, market crashes, and forced migration. Like Alexander (2004), Sztompka argued that the experience of a massive disruption by itself does not cause the cultural trauma; instead, it is the meaning members of a given culture assign to the event that establishes whether the event is deemed traumatic for the culture. According to Sztompka (2000), the nature of the event, the meaning and interpretation assigned to the event, and the degree to which the culture is able to resume its functions following the event determine the extent and severity of the cultural trauma experience.

When a culture is overwhelmed by a devastating traumatic incident, it loses its inherent functions to buffer anxiety and restore balance, and therefore its ability to protect and sustain its members (Devries, 1996). Salzman and Halloran (2004) defined cultural trauma on the basis of terror management theory, focusing particularly on indigenous populations. The authors argued that a strong and stable cultural worldview acts as a buffer to people's intrinsic fear of death and personal annihilation. When the cultural worldview of a group is threatened or damaged, anxiety takes root and serious psychological and behavioral dysfunction begin to transpire.

The theoretical perspective on cultural trauma advanced by Stamm and colleagues (Stamm et al., 2004) is also relevant to Indigenous groups. Their work on this subject targets the effects of colonialism, specifically the attendant clash between an incoming hegemonic culture

and the native culture. This culture clash causes severe disruptions in the social, cultural, and economic processes of the original culture, which leads to cultural disintegration. As members of the challenged group struggle to adjust to the new social reality, there is a loss of shared identity and familiar social structures. In contrast, the arriving culture flourishes and becomes more dominant, overshadowing the indigenous culture.

Although the concepts of collective and cultural trauma offer a coherent framework to grasp the implications of mass traumatic events on communities, cultures, and societies at large, neither of these constructs go as far as to explain how the effects of trauma in a collectivity can persist across generations. The concept of historical trauma provides a unique lens to understand the lasting imprint of collective violence and human rights assaults on successive generations. I explore the origins of this concept and its evolution in the next section.

Historical Trauma

Historical trauma represents the cumulative emotional and psychological wounding sustained by members of a collectivity, who share a common identity, affiliation, or situation, that continues to be borne across generations (Brave Heart, 2003; Brave Heart & De Bruyn, 1998; Crawford; 2013; Evan-Campbell, 2008; Gone, 2013; Mohatt et al., 2014). The concept of historical trauma rests on the premise that populations exposed to prolonged mass traumatic events, such as violent conflict, genocide, colonization, slavery, and repressive regimes, tend to manifest higher prevalence of physical and psychological morbidity, even several generations beyond the primary survivors who experienced directly the traumatic event(s) (Sotero, 2006). The distinctive feature of historical trauma is the transmission of the perpetrated grievance from one generation to the next, which sets off an intergenerational cycle of traumatic response (Brave

Heart, 2003; Danieli, 1998; DeGruy, 2005; Duran & Duran, 1995; Kellermann, 2001c; Sotero, 2006).

The Origins of Historical Trauma

The notion of intergenerational transmission of trauma is as ageless as the struggles of humankind. Several religious and classical literary texts, such as the Bible and the works of Euripides and Shakespeare, allude to the belief that the woes of the parents shall revisit their children (Danieli, 1998). This idea is also reflected in conventional wisdom in sayings like "the apple does not fall far from the tree" (Kellermann, 2001c).

Scientific interest in the intergenerational transmission of trauma emerged in the 1960s, essentially from clinical studies with Holocaust survivors and their offspring (Danieli, 1998; Dass-Brailsford, 2007; Kellermann, 2001c). Researchers noted that some of the children of Holocaust survivors exhibited traumatic responses that seemed to hark back to the harrowing experiences of their parents, despite not having witnessed first-hand the horrors of the Shoah (Rakoff, 1966; Rakoff et al., 1966). Rakoff et al. (1966) developed the concept of intergenerational trauma to explain the legacy of the Holocaust on second-generation survivors. In the ensuing two decades, researchers continued shedding light on the generational impact of the Jewish holocaust (Barocas & Barocas, 1973; Danieli, 1980, 198l; Kestenberg, 1972; Rosenthal & Rosenthal, 1980). The work of these investigators cemented the foundations of the field of multigenerational trauma. At the turn of the 21st century, publications on the intergenerational transmission of trauma in Holocaust survivors numbered over 400 papers (Kellermann, 2001c).

Meanwhile, scholars began to turn their attention to other populations that have a history of victimization, persecution, and gross human rights violations, such as African Americans

(Apprey, 1999; DeGruy, 2005); South Africans (Adonis, 2016); indigenous groups (Bombay et al., 2009; Brave Heart & DeBruyn, 1998); the children of Japanese American internment camps survivors (Nagata et al., 2015); Palestinians (Barron & Abdallah, 2015); Russians surviving the Stalin purge (Baker & Gippenreiter, 1998); Armenian refugees (Karenian et al., 2011); Kosovars (Schick et al., 2013), and Guatemalans (Ramos, 2013). Several of these scholars reported a range of emotional and behavioral challenges among the descendants of these groups (Mohatt et al., 2014). The phenomenon of intergenerational transmission of trauma was also extended to explain the psychological sequelae on children of survivors of domestic violence and sexual abuse (Simons & Johnson, 1998; Frazier et al., 2009), the children of war veterans (Harkness, 1993) and child soldiers (Song et al., 2014), and the offspring of perpetrators of mass political violence (Hardtmann, 1998).

Historical Trauma and Indigenous Populations

In the last two decades, most of the scholarly work on historical trauma has focused on colonized indigenous populations, including American Indian and Alaskan Native (AIAN) in the United States, First Nations and other Indigenous peoples in Canada, and the Aboriginal and Torres Strait Islanders in Australia (Sotero, 2006). The term historical trauma was popularized in the mid-1990s by Maria Yellow Horse Brave Heart (1995, 1998), a Native American clinical social worker and researcher, in response to her work with the Lakota tribe. Brave Heart (2003) defined historical trauma as "the cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences" (p. 7).

Drawing on the writings on Jewish Holocaust survivors and their descendants, Brave Heart and DeBruyn (1998) applied the construct of historical trauma to shed light on the disproportionate rates of behavioral health problems in Indigenous communities across North

America, such as the higher prevalence of suicide, child abuse, domestic violence, accidental deaths, and alcohol addiction. They related present-day mental health adversities facing Native Americans to the painful "legacy of chronic trauma and unresolved grief across generations" (Brave Heart & DeBruyn, 1998, p. 60) spawned by centuries of oppression at the hands of European colonizers and a European dominant culture. They termed the observed behavioral ramifications as historical unresolved grief.

Duran and Duran (1995) compared historical trauma in Native Americans to a "soul wound" resulting from extended persecution and subjugation over the life course and across generations. Whitbeck and colleagues (Whitbeck, Adams, et al., 2004) postulated that the ancestral historical losses (e.g. loss of kin, land, and culture) suffered by American Indians over the last 500 years can be linked to the historical loss associated symptoms (e.g. depression, anger, anxiety, shame, fear, and distrust of White people) manifested in contemporary generations.

Core Assumptions and Processes of Historical Trauma

Sotero (2006) conducted a thorough review of the literature on historical trauma in diverse populations and offered four assumptions underlying the phenomenon of historical trauma: (a) mass trauma is deliberately and systematically inflicted upon a target population by a subjugating dominant population or group; (b) the trauma is not caused by a single traumatic incident, but it is accrued over an extended period of time; (c) the trauma response affects the entire population; and (d) the magnitude of the trauma experience disrupts the natural projected historical course of the population leading to physical, psychological, social, and economic disparities that persevere across generations.

Sotero (2006), based on her examination of the literature, further explained that historical trauma is comprised of three components that mark three successive phases: (a) the historical trauma experience, (b) the historical trauma response, and (c) the intergenerational transmission of historical trauma. She explained that historical trauma proceeds from the subjugation of a cultural group or population by a dominant group. Members in the primary generation(s) are the initial victims of the systematic repression that is typically executed through four methods, including acute and chronic physical and psychological violence, economic destruction, cultural dispossession, and displacement or segregation. Survivors, having witnessed great losses, harrowing violence, and pervasive hardships that threatened the population's survival, must grapple with the physical (e.g., physical injuries, malnutrition, infectious and chronic diseases), psychological (e.g., fear, confusion), social (e.g., distrust), economic (e.g., loss of sources of income and sustenance), and cultural (e.g., lost traditions and beliefs) consequences of the mass trauma (Sotero, 2006). The resultant trauma is so intense that it thwarts prospects for healing and resolution, and in time its effects trickle down to the next generation and beyond through various pathways, such that subsequent generations experience similar consequences.

Historical Trauma and Present-Day Representations

Although the legitimization of physical violence and overt subjugation may be quelled over time, its vestiges often persist in the form of institutionalized racism and discrimination and social and economic disadvantage (Duran & Duran, 1995; DeGruy, 2005; Sotero, 2006). These forms of structural violence (Galtung, 1969) further entrench inequality and poverty (Adonis, 2016). The perpetuation of violence and injustice through other devious means speaks to the insidious and cumulative nature of historical trauma, consisting of both past and contemporary representations.

Green and Darity (2010) argued that historical trauma cannot be detached from the more proximate experiences of racial/ethnic discrimination, inequality, and hardship. The abolition of slavery did not put an end to the traumatic assaults on African American lives. Over time, the injustices of slavery morphed into other forms of violence and denigration, such as public policies and laws that sustain the underdevelopment of African American citizens in terms of housing, education, and employment opportunities, and the mass incarceration of Black youth (Cross, 1998). All these incidents of mass group trauma converge and contribute to cumulative trauma. Evans-Campbell and Walters (2006) developed the concept of colonial trauma response to represent the compounding effect of contemporary traumas caused by present-day injustices on preexistent historical traumas in colonized populations.

Historical Trauma and PTSD

Historical trauma was initially understood to be a generational form of PTSD or secondary PTSD (Baranowsky et al., 1998). As research on historical trauma continued to accumulate, important distinctions between historical trauma and PTSD became apparent, which helped differentiate the two (Evans-Campbell, 2008; Walters et al., 2011). Historical trauma is multilayered, in addition to its potential to be transmitted to successive generations. Historical trauma is collective, meaning that the trauma is shared by a group of people or population. However, unlike the notion of collective trauma that was discussed earlier in this chapter, historical trauma is also cumulative because the trauma is accrued over the life cycle and across multiple generations. Consequently, historical trauma does not conform to the nosological criteria of PTSD.

PTSD, as a diagnostic label, is based on the Eurocentric paradigm of health and illness, which focuses on treating discrete maladies that have individualized etiologies and solutions

(Goodkind, Hess, et al., 2012). Accordingly, the definition of PTSD offers little room to consider the psychosocial sequelae of widespread social disruption and cultural decimation at the group or population level. By contrast, the concept of historical trauma accounts for the collective experiencing of adversity and suffering (Gone 2007, 2013). Historical trauma symptoms are seen as a communal response to relentless violence, persecution, and oppression (Brave Heart & DeBruyn, 1998).

Furthermore, the concept of historical trauma takes into consideration the dynamic nexus of temporal, proximate, and distal factors that shape the experience of trauma (Sotero, 2006). It accommodates the social and cultural processes and the institutional contexts that prevail upon the trauma experience, as well as the historical legacy of a population. On the other hand, PTSD, as a diagnostic classification, is not concerned about the macro-level and historical factors that influence and perpetuate the traumatic response across generations (Evans-Campbell, 2008).

Historical Trauma and Related Terms

Today, historical trauma has become synonymous with the perennial suffering of Indigenous populations. The concept was considered clinically relevant to AIAN by both Native and non-Native behavioral health practitioners and it was endorsed by AIAN people (Brave Heart et al., 2011; Goodkind, LaNoue, et al., 2012). Furthermore, the definition of historical trauma proposed by Brave Heart (2003) has been adopted by several trauma scholars and practitioners, including SAMHSA (2014), and applied to other oppressed and persecuted populations.

Simultaneously, a plethora of other terms have been used in the literature to capture the generational aspect of historical trauma, such as transgenerational (Felsen, 1998), multigenerational (Danieli, 1998), intergenerational (Kellermann, 2001c), and cross-generational

trauma (Lowin, 1983). Some scholars introduced analogous concepts to describe the intergenerational legacy of chronic trauma in specific cultural groups, such as "soul wound" (Duran & Duran, 1995) for AIAN, "post-traumatic slave syndrome" for African Americans (DeGruy, 2005) and "colonial trauma response" (Evans-Campbell & Walters, 2006) for colonized populations.

Challenges in Historical Trauma Research

Notwithstanding the growing interest in the intergenerational transmission of trauma across various disciplines, scientific inquiry in this field is beset with complexity (Gottschalk, 2003; Sotero, 2006). Primarily, there is no clear consensus on the nature of historical trauma. Whereas some scholars have claimed that the concept of historical trauma is intuitive and considered it to be a universal phenomenon, others have taken a more cautious stance and treated historical trauma as a secondary phenomenon (Danieli, 1998). Also, some of the supporting constructs are ambiguous and backed by little empirical evidence (Brown-Rice, 2013; Evans-Campbell, 2008; Gone, 2009; Sotero, 2006). Further empirical research is required to operationalize and substantiate the concept of historical trauma and related constructs.

Scholarship on historical trauma is largely theoretical or based on clinical samples (Evans-Campell, 2008; Sotero, 2006). Additionally, the bulk of empirical research is qualitative (Sotero, 2006; Brown-Rice, 2013). Although qualitative inquiry is useful to elicit a nuanced understanding of complex phenomena, quantitative studies are needed to tease out the relationship between historical trauma and the psychosocial distress that plagues present-day generations. Another major challenge is establishing causal linkages between atrocities that happened in the distant past, in some cases going back several generations ago, and contemporary behavioral and social ramifications (Kirmayer, Gone, & Moses, 2014). Drawing

conclusions about causation is seriously impeded by the retrospective nature of such investigations. Furthermore, it is difficult to make sense of the diverse empirical studies that make use of disparate terminology and research approaches (Mohatt et al., 2014). Despite these setbacks, over the years there has been marked progress in exposing the effects and the transmission mechanisms underlying historical trauma.

The Intergenerational Transmission of Historical Trauma

Understanding how the cycle of trauma perpetuates itself across generations has important clinical implications for mental health practitioners; with understanding interventions can be developed that can mitigate the impact of historical trauma and minimize its impact across generations (Bombay et al., 2009). Several theoretical perspectives have emerged in a bid to shed light on the mechanisms by which traumatic events experienced by one generation can have lingering effects on subsequent generations (Kellermann, 2001c). The controversy in this domain is that, although the effects of historical trauma are evident, the course of transmission may not be as tangible. The mechanisms underlying trauma transmission are extremely complex and can be direct or indirect, overt or covert, and conscious or unconscious (Kellermann, 2001c).

In this section, I provide an overview of the major theoretical perspectives on how trauma is transmitted across generations and exacts a toll on the mental health and well-being of the descendants of initial survivors. All models offer a unique explanation of how successive generations find themselves living in the tyranny of their ancestor's violent history. In this section, I examine how the effects of trauma are relayed from one generation to another (the process of transmission), whereas in the next section, I discuss the effects of historical trauma on succeeding generations (the contents of transmission).

The Biological Perspective

Biological and genetic explanations are based on the premise that there may be a heritable physiological predisposition for developing historical trauma symptoms in second and later generations (Kellermann, 2001c). Biological models account for trauma-induced neuroendocrine changes, genetic mutations, and epigenetic modifications in DNA (deoxyribonucleic acid) expression that are passed on from one generation to the next. In this conceptualization, trauma is transmitted directly, yet unintentionally, to the offspring. This theoretical perspective is supported by compelling empirical evidence suggesting that historical trauma can be transmitted via biological and epigenetic processes that increase the ensuing generations' vulnerability to health risks and mental and physical illness (Danieli, 2007; Kellermann, 2013; Walters et al., 2011; Yehuda, Bell, Bierer, & Schmeidler, 2008; Yehuda et al., 2000, 2014; Yehuda, Halligan, & Bierer, 2001; Youngson & Whitelaw, 2008).

A number of clinical studies have revealed that the children of survivors who developed PTSD tend to display an increased reactivity to stressors that makes them more susceptible to PTSD (Yehuda & Bierer, 2007; Yehuda et al., 2000, 2014). Yehuda and colleagues (Yehuda et al., 2000) found that the children of Holocaust survivors who developed PTSD had significantly lower cortisol levels than children whose parents did not have PTSD. Offspring who had a lifetime diagnosis of PTSD and whose parents both developed PTSD had the lowest cortisol levels among all study groups. The researchers identified low cortisol levels as a vulnerability marker of PTSD in the offspring. Yehuda and her team concluded that parental PTSD, particularly maternal PTSD, is not only a significant risk factor for PTSD in the offspring, but it is associated with low cortisol levels in the offspring, even in the absence of lifetime PTSD in the latter (Yehuda & Bierer, 2007; Yehuda et al. 2000, 2001, 2008). These findings suggest that

parental exposure to traumatic experiences can provoke an impaired neurochemical response to stress in survivors that is later inherited by the offspring.

Volkan (1997) paralleled the transmission of this genetic memory code to a "psychological DNA" (p. 44) that is planted in the younger generation. The inherited stress reactivity creates a biological vulnerability in the offspring's ability to adapt and cope with stressful events of their own. Some researchers explained that these epigenetic changes may not be expressed until secondary survivors are confronted with severe stressful situations in their own lives (Bradley et al., 2008; Kaufman et al., 2004; Kendler et al., 2005). Their claims speak to the intricate interplay between innate neurochemical processes and external psychosocial stressors.

Furthermore, researchers have suggested that maternal exposure to traumatic events during pregnancy can affect the fetal epigenetic programming of the hypothalamic pituitary adrenal (HPA) axis by virtue of changes in the placenta, thereby altering permanently the offspring's neurochemical functioning (Owen et al., 2005; Sosnowski et al., 2018; Yehuda & Lehrner, 2018). Maternal stress during pregnancy has been linked to adverse outcomes in children, such as psychiatric disorders and several pediatric illnesses (Seckl & Meaney, 2006; Tegethoff et al., 2011). Additionally, the prenatal environment in concert with subsequent early life experiences can further aggravate the adult offspring's stress response (Francis et al., 2003).

Epigenetics is currently one of the leading fields spearheading the study of intergenerational transmission of trauma (Kellermann, 2001c, 2013). Genetic models of transmission were met with some criticism by Holocaust survivors and their families because of their similarity to the Nazi ideology of eugenics; however, this theoretical perspective has great potential to advance understanding of the intergenerational processes that sustain the

perpetuation of trauma in future generations (Kellermann, 2001c). Based on the principle that traumatization has a hereditary etiology similar to how certain diseases are passed on from one generation to another, biological and genetic models afford a strong empirical basis for further research.

The Psychoanalytic Perspective

Psychoanalytic interpretations of trauma transmission have long dominated the field of intergenerational trauma (Kellermann, 2001c). Psychoanalytic models explain how the children of primary survivors internalize the repressed and unresolved trauma of their parents through mechanisms that operate outside conscious awareness (Volkan, 1997). From this perspective, the younger generation acts like a reservoir, absorbing the unwanted experiences and feelings of their parents and feeling compelled to undo the harms and the trauma inflicted on their forbearers.

Volkan (1996), a leading proponent of the psychoanalytic perspective on the intergenerational transmission of trauma, argued that when initial survivors fail to meaningfully mourn the trauma and regain psychological coherence by repairing the traumatic rupture in their self-identity, they externalize the traumatized self-representation. Surviving parents may fulfill this externalization by bequeathing the traumatized self-representation to the self-representation of the developing child. The unconscious fantasy of the parents is that the child successfully mourns and resolves the trauma in their stead, and to this end they assign to the child various tasks associated with their unfinished mourning.

Projective identification was suggested as a possible explanation for the transmission of historical trauma (Rowland-Klein & Dunlop, 1998). In projective identification, the children introject the parent's projected trauma-related feelings and anxieties as if they were their own

problems. Accordingly, the children feel obligated to live in their parents' past. Auerhahn and Laub (1998) explained how the parent's psychic trauma invades the children's internal reality and becomes an "unconscious organizing principle" (p. 22). The authors also discussed the displacement of the parent's repressed grief on their children who become like "memorial candles" (Wardi, 1992, p. 40) memorializing perished loved ones and other losses endured as a result of the traumatic events.

Other psychoanalytic explanations draw attention to the self and object relations of the survivor's offspring. The toxic parent-child relationship patterns become internalized self and object representations that continue to wield influence on the offspring's development and interpersonal life (Kellermann, 2001c). The children consequently become trapped in a struggle between wanting to preserve their ties to their traumatized parents and trying to differentiate themselves from the tyranny of their parents' unintegrated past (Barocas & Barocas, 1980; Katz, 2003; Kellermann, 2001c).

The Social Learning Perspective

Social learning and socialization models of historical trauma transmission, unlike psychoanalytic interpretations, are concerned with the conscious and direct processes and influences of first generation survivors on their offspring through childrearing behaviors (Kellermann, 2001c). Literature on parenting has suggested that parental behaviors serve as a template for children to acquire stable traits, such as self-esteem and self-efficacy, which promote the development of effective coping skills and buffer individuals against the deleterious outcomes of stressful events (Miller et al., 1999; Roberts et al., 1996).

Parental influences on children can take the form of prohibitions, taboos, and warnings, such as messages like "be careful!" and "don't trust anybody!" (Kellermann, 2001c, p. 263).

Although these cautionary exhortations are intended to safeguard the children from harm, they also can instill fear and distress in the offspring (Weingarten, 2004). Children are thus raised with a sense of impending danger or doom (Kellermann, 2001c)

Inadequate role modeling may also play a role in the transmission of traumatic responses (Kellermann, 2001c). According to social learning theory (Bandura, 1977), children learn vicariously through observation and imitation of their parents' behavior. Kellermann (2001c) reported that some children of Holocaust survivors adopted the behaviors and emotional states of their parents. Outside the domain of historical trauma, inadequate role modeling was identified as a factor that fuels cycles of violence within families (O'Keefe, 1994; Truscott, 1992). Markowitz (2001) found that witnessing family violence as a child is associated with favorable attitudes toward violence against both children and spouses. Attitudes mediate the relationship between witnessing violence while growing up and engaging in violent behavior. Along the same lines, Brave Heart (1999b) argued that the forced removal of Indigenous children to boarding schools not only deprived these children from traditional parenting role models but, in many cases, it exposed them to harsh treatment, abuse, and neglect. Over time, these adverse conditions found their way into the parenting styles of contemporary AIAN generations as manifested by the use of strict physical discipline, emotional disengagement, and lack of parental involvement.

Several scholars have alluded to a possible impairment in parenting capacity of primary victims (Brave Heart, 1999; Campbell & Evans-Campbell, 2011; Danieli, 1998). Referring to the experiences of Holocaust survivors, Walker (1999) claimed that exposure to traumatic incidents and victimization undermines the survivors' capacity for trust and intimacy, which in turn interferes with parental engagement with their children. However, empirical research on the

subject has yielded conflicting evidence (Kellermann, 2001a). In a study investigating parenting behavior among Holocaust survivors, Kellermann (2001a) discovered that although adult children of Holocaust survivors rated their parents higher on trauma transmission, there were no significant differences with respect to other childrearing practices, thus refuting the prevailing belief that Holocaust survivors functioned deficiently compared to other parents. Certain parenting styles such as verbal hostility in authoritarian parenting were associated with behavioral challenges in children by transmitting the trauma symptoms (Schwerdtfeger et al., 2013), whereas other parenting styles such as open, loving communication were linked to increased resilience in the offspring (Braga et al., 2012; Gewirtz et al., 2008).

The Family Systems Perspective

Family systems and communication models emphasize the family environment wherein the transmission of trauma takes place (Kellermann, 2001c). This theoretical perspective seeks to understand how historical trauma is transmitted by way of parent-child interactions via disrupted family dynamics and communication patterns. Several scholars espousing this view have focused on difficulties in individuation and separation, and scarred parent-child attachment patterns (Barocas & Barocas, 1980; Bar-on et al., 1998; Klein-Parker, 1988).

Klein-Parker (1988) reported that in highly closed family systems of Holocaust survivors, parents and children alike display an exaggerated involvement and concern over the welfare of the other. Each side lives vicariously through the other and is committed to shielding the other party from painful memories and experiences. Consequently, children become enmeshed in their parents' emotional distress, which impedes them from gaining true independence.

Kellermann (2001c) observed that, in some cases, the children of Holocaust survivors ended up assuming the role of parent to their own parents. This reversal of roles, which is also

termed “defensive care-taking” (Metzger Brown, 1998), “narcissistic parenting” (Rosenberger, 1973), or “parent-child role diffusion” (Zilberfein, 1996), makes the children feel like orphans because of their unmet dependency needs. The distorted family dynamics and strained attachments preclude the children of primary survivors from developing secure attachments to loved ones that are free from anxiety, apprehension, and hopelessness (Katz, 2003).

Specific communications styles such as over-preoccupation and double-bind communication are also thought to mediate the transmission of trauma to the offspring (Kellermann, 2001c). Over-preoccupation engenders a sense of fear, vulnerability, and sadness in the children (Sorcher & Cohen, 1997). On the other hand, double-bind communication is fraught with contradictions, which makes it awkward for the children to respond adequately to their parents’ wishes and requests (Kellermann, 2001c). Double-bind messages confuse communication, induce guilt, and restrict the emotional development of the child.

In some situations, both the parents and the children try to shield one another from painful experiences by withholding communication about the parents’ traumatic past. Danieli (1998) named this communication pattern the “conspiracy of silence” (p. 4). Silence was identified as a key mechanism by which the effects of the trauma are conveyed from primary survivors to their offspring (Weingarten, 2004). Several authors documented the dire consequences of silence in families of survivors of violent conflict and war. Children who grew up in families in which the parents' trauma was not discussed openly, but was implicitly expressed through other behaviors, were found to be more susceptible to the intergenerational consequences of trauma (Fargas-Malet & Dillenburger, 2016; Kellermann, 2001c; Wiseman et al., 2002).

Silence functions in complex ways and can be as powerful as words in conveying traumatic messages (Ancharoff et al., 1998; Danieli, 1998; Op den Velde, 1998; Wiseman et al., 2002). Silence can prompt children to fantasize about the nature of the traumatic events in their parents' past (Ancharoff et al., 1998; Daud et al., 2005). At times the tragedy is shrouded in absolute silence, whereas in other situations the silence is punctuated with scant facts and details that are often accompanied by incongruent affect (Weingarten, 2004). In some cases, parents try to "unconsciously strike a compromise" (Weingarten, 2004, p. 52) by communicating the trauma by other means, often through behavior that has embedded meanings, such as how they respond to stimuli that remind them of the traumatic experiences. Silence can overshadow not only the relationships within the family environment, but the interactions in entire communities or societies, as will be discussed in the next subsection.

The Sociocultural Perspective

Sociocultural models target the community and societal contexts that facilitate the intergenerational transmission of trauma (Weingarten, 2004). This theoretical perspective is of particular interest to the study at hand because it underlines the collective dynamics fueling the generational transmission of historical trauma, thus attesting to the need for collective interventions.

From a sociocultural perspective, historical trauma is transmitted via the breakdown of social structures and processes and the disruption of community- and culture-based protective factors as a result of the violent and oppressive tactics implemented by the perpetrating group (Campbell & Evans-Campbell, 2011; Chandler & Lalonde, 1998; Somasundaram, 2007, 2014; Ungar, 2004). The breach in cultural continuity through the loss of cultural beliefs, norms, and language not only undermines a group's cultural identity and pride, but it threatens the welfare

and resilience of the community and its constituents (Chandler & Lalonde, 1998, Ungar, 2004). Chandler and Lalonde (1998) noted that First Nations communities in Canada that enjoyed higher cultural continuity had lower rates of youth suicide. The researchers concluded that cultural continuity serves as protective factor against behavioral health problems. Along the same lines, Brave Heart & DeBruyn (1998) explained how the outlawing of culture-based grieving practices among AIAN tribes led to mass unresolved grief. Similarly, Danieli and colleagues (Danieli et al., 2016) found that cultural continuity through religious affiliation or practice had an indirect buffering effect on the intergenerational trauma impacts sustained by Holocaust survivors' offspring; the greater the continuity, the lesser the impacts on the offspring. The researchers also reported that relocating in Israel had a reparative effect on Holocaust survivors and their offspring, which seems to imply that re-establishing cultural ties had a protective influence on this population.

The sociocultural perspective also emphasizes the role of collective memory, public narratives, and rituals (Mohatt et al., 2014; Volkan, 1996, 1997, 2009; Wessells & Strang, 2006). The concept of post-memory advanced by Hirsch (2001) speaks to the insidious influence of collective memory and public narratives on the descendants of survivors of cultural violence. Post-memories represent the collection of stories, images, and customs that children grow up with that carry traumatic fragments of their ancestors' past. The messages transmitted by these narratives are so powerful that they come to dominate the offspring's consciousness and become memories in their own right. These reclaimed memories impose a historical order on successive generations that perpetuates the lived experiences of the cultural trauma and its effects over time.

A similar explanation was offered by Volkan (1996), who coined the concept of chosen traumas to account for the legacy of trauma across generations. According to Volkan (1996),

chosen traumas are select traumatic experiences that become etched in the collective memory of a group and are passed on to successive generations. He explained that at the collective level there is a shared mental representation of the traumatic past, which reflects the group's inability to mourn the multiple losses of people, land, and prestige, and a failure to redeem the history of humiliation inflicted on them by a subjugating group. Chosen traumas can be reactivated in the present when a group perceives that its identity is being threatened, which can lead to tragic and destructive consequences.

Abramowitz (2005), in a study conducted in the Guinean Languette region, found that community members in local communities that constructed public narratives of violence, destruction, and cultural decimation following the civil conflicts in neighboring Sierra Leone and Liberia reported greater post-conflict distress, including fear, anxiety, and depression, and higher rates of posttraumatic stress symptoms. On the other hand, in communities where the collective narratives conveyed resistance to violence and community and cultural perseverance, the rates of psychological distress and PTSD symptomatology were lower.

Silence can permeate traumatized communities when community members, or even societies at large, avoid discussing openly the traumatic incidents (Danieli, 1998; Lin et al., 2009). Silence at the group or national level operates in tandem with and in the same fashion as silence at the individual and family levels (Weingarten, 2004). Danieli (1998) used the term "conspiracy of silence" (p. 4) to describe societal reactions to Jewish Holocaust survivors, which were marked by avoidance, indifference, and denial. The silence ensuing mass traumatic events can undermine the survivors' sociocultural reintegration and promote further isolation, alienation, and mistrust of society (Danieli, 1998). Additionally, silence in communities and societies can have devastating long-term implications because it robs younger generations of the

opportunity to learn from the past and make sense of their present circumstances (Ramos, 2013). This lack of knowledge has the potential to sustain the interlinked cycles of violence and trauma.

Silence is often accompanied by shame that can reside at multiple levels, including individuals, families, communities, and nations (Weingarten, 2004). Gilligan (1997) argued that silence harbors fear, whereas shame spawns violence and retaliation. Shame is thus another societal mechanism that underlies the transmission of trauma across generations (Kaufman, 1992). Several authors referred to collective shame as humiliation, and described how it infiltrates and becomes embedded in the social relations and institutional structures of the affected group (Lindner, 2001a, 2001b; Volkan, 1997, 1999, 2000, 2001). Lindner (2001a) argued that humiliation can take on a traumatic tone not only at the individual but also at the group level. Humiliation forces whole communities or cultures to bottle up their resentment, which fuels the desire for retaliation and revenge. Consequently, succeeding generations who absorb this humiliation may develop retaliatory fantasies (Weingarten, 2004). When one generation fails to restore social and political justice, this failure becomes the next generation's legacy and mission. Thus, sociocultural mechanisms of transmission of historical trauma can engender a "destructive aggression from one generation to the next" (Apprey, 1999, p. 32).

Furthermore, proximate factors such as overt and institutionalized racism and discrimination, daily microaggressions, socio-economic inequalities, and poverty, besides having a traumatic import of their own (Mollica, 2009), provide salience to the ancestral trauma in succeeding generations (Volkan, 2009). Volkan (2009) contended that the offspring's ability to transcend parental helplessness is by and large dependent on the extent to which the historical conditions that were responsible for their parents' helplessness have improved. If contemporary conditions are dire, the traumatic memories of past generations can become a focal or

crystallizing point that justifies present-day distress, abuse, and neglect, resulting in a perpetual sense of powerlessness (Apprey, 1999; Volkan, 2009).

The Integrative Perspective

Each of the perspectives described in this section represents a specific lens through which the intergenerational transmission of trauma can be conceptualized. However, no one mechanism can singularly account for the nexus of factors that contribute to how traumatic responses are passed down from one generation to the next (Weingarten, 2004). Kellermann (2001c) drew attention to the need to adopt an integrative view on intergenerational trauma transmission that assumes a combination of ecological factors, including biological predispositions as well as psychological processes, family influences, and the social milieu. Integrative approaches are particularly relevant to this study because they acknowledge the different factors at multiple systemic levels that aggravate or mitigate the effects of historical trauma in successive generations. This outlook is consistent with the bioecological model (Bronfenbrenner & Ceci, 1994), which is the conceptual framework on which the study was based. The trauma and the continuity of self: a multidimensional, multidisciplinary, integrative (TCMI) framework (Danieli, 1998) and the transgenerational transmission of historical trauma (TTHT) model (Kirmayer et al., 2014) are two examples of integrative models.

The TCMI Model. The TCMI model was developed by Danieli (1998) to portray the complex nature and far-reaching scope of the devastation generated by mass traumatic events, thereby challenging reductionist explanations that focus on unidimensional components of trauma. The TCMI model takes into account the various contextual dimensions where the trauma is located. According to the TCMI framework, an individual's identity is based on the different interactions between multiple systems or spheres, including the "the biological and

intrapsychic; the interpersonal-familial, social, and communal; the ethnic, cultural, ethical, religious, spiritual, and natural; the educational/professional/occupational; the material/economic, legal, environmental, political, national, and international" (Danieli, 1998, p. 7). In an optimal scenario, individuals have psychological access to, and can move freely across, all identity dimensions.

Exposure to catastrophic events disrupts and creates a rupture in some or all of these identity spheres, and as a result individuals get stuck in a state of "fixity" (Danieli, 1998, p. 7). The severity of an individual's identity rupture, fixity, and disorientation is dependent on the timing, duration, intensity, and meaning of the trauma, the coping strategies availed to cope with the traumatic situation, and the presence or absence of post-trauma secondary traumatization, which Danieli (1998) broadly defined as the conspiracy of silence. Psychological healing and recovery are possible only if the trauma is fully integrated across the relevant identity dimension or systems, a task that cannot be accomplished by individuals on their own. Healing requires the involvement of all the social actors associated with the trauma. In the absence of proper intervention and healing, the identity rupture and fixity are carried forward into the future and passed down to successive generations.

The TTHT Model. The TTHT framework (Kirmayer et al., 2014) postulates that intergenerational transmission of trauma can happen at multiple levels, including (a) the intrapersonal or biological level through epigenetic alterations in stress reactivity; (b) the interpersonal level through disrupted parenting; (c) the familial level through exposure to adverse childhood experiences, such as domestic violence; (d) the community level through the breakdown of social networks and the loss of culture-based protective factors; and (e) the national level through cultural suppression and disenfranchisement and structural violence. The

model highlights the different processes at play that enable the transmission of trauma from one generation to the next at multiple levels, including: epigenetic dysregulation of the HPA axis; mental health problems and other challenges to psychological well-being, such as diminished self-esteem and self-efficacy; family dysfunction, domestic violence and abuse; threats to community integrity, such as community disorganization, social problems, and violence; and political disempowerment and loss of collective cultural identity and efficacy. Although the model can be applied to different populations affected by historical trauma, it is based on the historical legacy of Indigenous peoples in North America as a result of colonization and centuries of cultural oppression.

Integrative models like the TCMI and the TTHT capture the dynamic cascade of biological, psychological, behavioral, and environmental processes that may contribute to the generational transmission of trauma (Bombay et al., 2009). All of these processes can have either additive or synergistic effects. Because these various elements are not comparable across individuals, integrative models shed some light on the variability in the inherited traumatic responses witnessed in ensuing generations. In the next section, I discuss the psychosocial manifestations of historical trauma at the individual, family, and community and society levels.

The Multilevel Effects of Historical Trauma

The literature on psychic trauma suggests that individual and collective responses to orchestrated mass violence differ from the psychosocial effects precipitated by major accidents or forces of nature (Boyd Webb, 2004). At the individual level, traumatic events that were perceived as random and uncontrollable, were human-instigated, or resulted in separation from one's family were associated with greater PTSD symptomatology (Evans-Campbell, 2008). The psychosocial consequences of historical trauma on the offspring of survivors of mass violence

and gross human rights violations have been reported in several cultures, most prominently among the descendants of Holocaust survivors (Yehuda & Beirer, 2007).

The consequences of historical trauma are not restricted to individual symptoms and manifestations. Mass traumatic events take a toll not only on individual well-being, but on family functioning and the social fabric of communities and societies as well (Bombay et al., 2009; Evans-Campbell, 2008). Traumatic responses are played out at different levels, including the individual, family, community, and society levels, all of which are inextricably interconnected. Individual responses to historical trauma are shaped by family experiences, and both individual and family manifestations are influenced by community-level impacts. At the same time, community reactions are continually reinforced by experiences at the individual and family levels. Evans-Campbell (2008) underscored the necessity of adopting a multilevel approach to understanding and addressing the impact of historical trauma, which takes into account individuals, families, and communities. Despite the growing impetus to consider the broader repercussions of historical trauma, most of the scholarship in this area focuses on individual and, to a lesser extent, on family impacts, overlooking the lasting scars that a legacy of violence and oppression leaves on communities and societies (Evans-Campbell, 2008; Somasundaram, 2014).

Individual Responses to Historical Trauma

At the individual level, the literature suggests that the descendants of primary survivors of extended mass political violence and subjugation tend to manifest increased psychological distress, diminished mental health, and an elevated risk to pathological symptoms. Researchers who studied the offspring of Holocaust survivors were the first to investigate the

intergenerational impact of mass traumatic events on successive generations (Felsen, 1998; Solomon 1998).

Clinical observations and a number of empirical studies documented a range of disturbances in emotions, behaviors, attitudes, worldviews, and relationships among the direct descendants of Holocaust survivors (Danieli, Norris, Lindert, Paisner, Kronenberg, et al., 2015). Kellermann (2001c) clustered the symptoms reported in clinical samples of this population under four domains: (a) self (e.g., impaired self-esteem, over-identification with the parents' victim/survivor status, and need to compensate for parental losses); (b) cognition (e.g., catastrophic expectancy, preoccupation with death, distress upon exposure to reminders of the Holocaust); affectivity (e.g., annihilation anxiety, dysphoric mood, feelings of grief complicated by guilt, and increased vulnerability to stressful events); and interpersonal functioning (e.g., exaggerated family attachments and dependency, and difficulties in entering intimate relationships and handling interpersonal conflicts).

Several empirical studies with non-clinical samples indicated that second generation Holocaust survivors were more likely to experience general psychological distress, such as low self-esteem, and higher levels of depression, anxiety, anger, guilt, mistrust, and somatization as well as difficulties in coping with stressful situations (e.g., Dekel et al., 2013; Gangi et al., 2009; Wiseman et al., 2006). Some researchers reported increased vulnerability to PTSD, depression, and anxiety disorders (e.g. Leen-Feldner et al., 2013; Letzter-Pouw et al., 2014; Yehuda et al., 2001, 2008; Yehuda et al., 1998).

In a series of studies, Yehuda and colleagues (Yehuda et al., 1998, 2001, 2008) sought to shed light on the vulnerability of second-generation Holocaust survivors to PTSD and other psychiatric diagnoses. Yehuda et al. (1998) found that adult offspring of Holocaust survivors

had an increased vulnerability to develop PTSD and other psychiatric disorders, such as major depression and anxiety disorders, in response to personal trauma, compared to adult controls. In another study, Yehuda and her team (Yehuda et al., 2001) established parental PTSD as a significant predictor of offspring PTSD. Additionally, parental Holocaust exposure was related to lifetime depressive disorder in the offspring. In a later study, Yehuda et al. (2008) concluded that maternal PTSD, rather than paternal PTSD, predicted PTSD in adult offspring. Furthermore, the presence of PTSD in either parent was associated with offspring depression, whereas parental traumatization was linked to offspring anxiety disorders.

The increased vulnerability of second-generation Holocaust survivors to psychopathology has been the subject of great controversy among researchers, primarily because there is limited consensus about the impacts of the Holocaust on this population (Danieli, Norris, Lindert, Paisner, Kronenberg, et al., 2015). Various empirical, review, and meta-analysis studies did not establish that offspring of Holocaust survivors were more susceptible to pathological effects than comparable controls (e.g., Kellermann, 2001b; Levav et al., 2007; Major, 1996; Schwartz et al., 1994; van Ijzendoorn et al., 2003). The conflicting findings reflect in part the substantive and methodological inconsistencies that blight research on the mental health of Holocaust survivors and their descendants, including discrepancies in assessment instruments and sampling methods, types of control group used, age and period influences, and heterogeneity of impact (Danieli, Norris, Lindert, Paisner, Kronenberg, et al., 2015). For example, early studies typically relied on case reports and non-random small samples. A number of studies did not have an adequate comparison group or had no control group at all and utilized nonspecific or non-validated measures. Additionally, some researchers criticized the underlying presumption of psychopathology in Holocaust survivors and their offspring (Solkoff, 1992).

In an effort to circumvent the contradictory evidence on whether or not the offspring of Holocaust survivors manifest greater psychopathology, Danieli and colleagues (Danieli, Norris, Lindert, Paisner, Kronenberg, et al., 2015; Danieli et al., 2017) sought instead to identify factors that placed second-generation survivors at greater risk for developing mental illness. To overcome the dearth of validated instruments that are tailored to measure intergenerational trauma impacts on Holocaust survivors' offspring, the research team developed a 36-item scale to assess the reparative adaptational impacts on this population. Reparative adaptational impacts represent the varied and multifaceted consequences of the Holocaust on the offspring, and capture the intrinsic yearning of the second generation to undo and repair the harms of the past and heal their parents and themselves. The scale is comprised of six factors: (a) insecurity about own competence, (b) need to protect one's parents, (c) need for power or control, (d) obsession about the Holocaust, (e) defensive psychosocial constriction, and (f) immature dependency. The instrument has a strong internal consistency (α=.91) and concordance between English and Hebrew versions ($\varphi \leq .95$). In a subsequent study, Danieli and colleagues (Danieli et al., 2017) used the newly developed scale and noted that participants who had a diagnosis of major depressive episode (MDE), PTSD, or generalized anxiety disorder (GAD) in the previous 12 months reported stronger reparative adaptational impacts. The findings suggested that the severity of the offspring's reparative adaptational impact, particularly features related to insecurity about one's competence, predicted the incidence of these psychiatric conditions.

Similar historical trauma manifestations were documented in other populations that survived cataclysmic historical events, such as AIAN, South Africans, and Palestinians. Reported symptoms include: intense sadness, anger, survivor guilt, a sense of helplessness or powerlessness, emptiness, denial, psychic numbing, memory loss, depersonalization,

hypervigilance, nightmares, fixation on the traumatic event(s), identification with death or the deceased, unresolved grief, and isolation (Adonis, 2016; Barron et al., 2013; Braveheart, 1998, 1999a; Brave Heart & DeBruyn, 1998; Daud et al., 2005; DeGruy, 2005; Duran & Duran, 1995; Whitbeck, Adams, et al., 2004).

Brave Heart (1998) coined the term "historical trauma response" (p. 288) to describe the constellation of behavioral and psychological responses to massive group trauma. The concept of historical trauma response was originally developed to capture the traumatic reactions in AIAN individuals; however, it can be applied to other cultural groups affected by historical trauma. Common manifestations of historical trauma response are depression, anxiety, low self-esteem, survivor guilt, anger, trouble recognizing and expressing emotions, rumination over past traumatic events and lost ancestors, somatic symptoms, self-destructive behavior, and suicidal ideation and behavior. Self-destructive behavior is usually exhibited as substance abuse, which is an attempt to numb painful feelings through self-medication (Brave Heart, 2003). In a study with 447 two-spirit AIAN adults living in urban settings, participants who were raised by a parent who attended boarding schools were more likely to have GAD, sub-threshold PTSD symptoms, and suicidal thoughts in their lifetime compared to participants with no history of boarding school (Evans-Campbell et al., 2012). Historical unresolved grief is an associated response that accompanies the historical trauma response, which represents the impaired grief proceeding from cumulative losses (Brave Heart & DeBruyn, 1998). Among AIAN people, historical unresolved grief was exacerbated by the prohibition of Indigenous burial practices and ceremonies.

In an attempt to operationalize the concept of historical trauma, Whitbeck and colleagues (Whitbeck, Adams, et al., 2004) developed the Historical Loss Scale and a Historical Loss

Associated Symptoms Scale to empirically measure the impacts of historical trauma in American Indian elders in two large reservations. The Historical Loss Scale consists of 12 items that specify different types of loss identified by Indigenous elders, such as loss of land, culture, traditional ways, family ties, self-respect, and trust. The Historical Loss Associated Symptoms Scale also includes 12 items and characterizes historical trauma impacts such as sadness, anger, shame, isolation, and discomfort when around White people. Both instruments have a high internal reliability; the Historical Loss Scale and the Historical Loss Associated Symptoms Scale have Cronbach's alpha scores of .94 and .90, respectively. The study revealed that, although the study participants were generations removed from the historical events that wrought devastation on their ancestors, the associated trauma was still present in their emotional lives (Whitbeck, Adams, et al., 2004). A significant percentage of the participants had frequent thoughts about specific historical losses, which were related to feelings of anger, intrusive thoughts, discomfort around White people, and distrust of White people's intentions.

Family Responses to Historical Trauma

In families, historical trauma manifests itself in more subtle but profound ways through the disruption of family dynamics (Evan-Campbell, 2008). Intergenerational trauma experts have claimed that historical trauma can emerge as an organizing concept in family systems (Danieli, 1998). At the family level, researchers have largely focused on strained parent-child relationships (Barocas & Barocas, 1980; Bar-On et al., 1998; Campbell & Evans-Campbell, 2011), loss of traditional parenting practices (Brave Heart, 1999b; Chase, 2011; Kellermann, 2001a), and household dysfunction (Bombay et al., 2011).

Bar-On and colleagues (Bar-On et al., 1998) conducted three studies with second-generation Holocaust survivors in Canada, the Netherlands, and Israel to shed light on the family

impacts of the Holocaust. Their study in Canada (*n*=57) revealed two central themes that shaped the relationship patterns between the children and their parents. A majority of the participants felt burdened by their parents' sadness, which influenced how they related to and interacted with their parents as well as their overall behavior. The researchers found that the offspring worked to be exemplary children by trying to please their parents and not adding to the pain and distress of their parents and by shunning open discussions about the Holocaust for fear of eliciting painful memories. Additionally, many respondents mentioned "pervasive and persistent" (Bar-On et al., 1998, p. 134) feelings of guilt, with some participants believing that they were not entitled to experience happiness because their loved ones were denied this privilege.

In the Netherlands study, Bar-On et al. (1998) noted that the children of Holocaust survivors (*n*=30) were incessantly preoccupied with their parents' trauma, and thus felt committed to keep the family together, which interfered with their separation and individuation. The offspring of Holocaust survivors felt more responsible for taking care of their parents than the participants in the random comparison group (*n*=30), and in some cases they had to assume the role of parents. The children of Holocaust survivors also experienced their parents as excessively over-protective and committed. Role reversal and expectations to fulfill particular roles within the family, such as replacing loved ones lost to the Holocaust or serving as a testimony to the losses and hardships endured by the family, were noted by other intergenerational trauma scholars (Felsen, 1998, Wardi, 1992).

In the biographical study conducted in Israel, Bar-On et al. (1998) exposed a similar dialectic, the protagonist's efforts to please his parents and the resultant failure to measure up to their aspirations. The participant also experienced ambivalence between accommodating to his father's expectations and claiming his individual autonomy. Similar struggles for autonomy and

independence were reported in a well-controlled study that assessed differences in family environment, adjustment, and coping among adult children of Holocaust survivors (*n*=20), adult children of immigrants (*n*=17), adults who self-identified as Jews and whose parents were born in the United States and were not Holocaust survivors (*n*=20), and non-Jewish adults whose parents were born in the United States (*n*=16) (Rose & Garske, 1987). The study results indicated that the Holocaust survivors' offspring were more likely to experience their parents as discouraging independence and self-sufficiency compared to the participants in the three comparisons groups.

In a previous series of biographical analyses, Bar-On (1995) drew attention to the censored communication between Holocaust survivors and their offspring, erecting a "double wall between the two generations" (p. 20). While parents resisted broaching about the traumatic events to avoid re-experiencing the trauma or exposing their children to the horrors in their past, the offspring responded to their parents' need to keep silent by steering away from the subject. In some cases, the censorship was enacted by the children to protect themselves from being overwhelmed by their parents' stories. Second-generation survivors felt that the poignancy of their parents' experiences overshadowed and downplayed their own life experiences and personal difficulties. Coles (2011) discussed how silence in families can potentially undermine the offspring's' psychological health, identity formation, and ability to develop intimacy with their parents.

Similar findings were reported in a small study conducted with two-spirit American Indian women (Walters et al., 2006). The study participants were wary of burdening their families with their problems and concerns. Additionally, they talked about their tendency to

minimize their own problems, which in their opinion paled in comparison to the overwhelming tragedies suffered by their ancestors.

In a study with second-generation Holocaust survivors, Danieli et al. (2016) investigated the relationship between parental factors, including parental posttrauma adaptational styles and the offspring's reparative adaptational impact. Posttrauma adaptational styles are coping and survival strategies availed by primary survivors during and after the Holocaust that in time shaped the survivor family's life, including their children's upbringing and identity and psychosocial development. In an earlier study, Danieli and colleagues (Danieli, Norris, Lindert, Paisner, Engdahl, & Richter, 2015) identified three distinctive posttrauma adaptational styles: victim, numb, and fighter. Danieli et al. (2016) discovered that the severity of both the mother's and father's victim styles were the strongest predictors of the offspring's reparative impact. A parent's posttrauma victim style was characterized by overprotectiveness, emotional lability, and being stuck in the trauma. Additionally, the mother's numb style exerted an additive, yet independent, effect on children's reparative adaptational impact, thereby suggesting that the overall effect of mothers' posttrauma adaptational style on the offspring was stronger. A parent's numb posttrauma style was defined by emotional disconnection, conspiracy of silence within the family, and intolerance of weakness.

Researchers have been also interested in the effects of historical trauma on parenting styles (Brave Heart, 1999b; Danieli, 1998; Kellermann, 2001a; Walker, 1999). In a study with 159 Holocaust survivors' offspring and 151 control participants, Kellermann (2001a) identified four major patterns of parental behaviors through factor analysis: transmission, affection, punishment, and overprotection. Only transmission was significantly higher among second

generation Holocaust survivors' compared to the control group. The results of this study were based on a convenience sample, and thus need to be interpreted with caution.

Several scholars who investigated the impacts of historical trauma in AIAN and First Nations families focused on the parents' out-of-home upbringing in boarding/residential schools or foster care (Brave Heart, 1999b; Brave Heart & DeBruyn, 1998; Chase, 2012; Cross, 1986). The displacement of children away from their families of origin deprived these generations of traditional parental role models, thereby interrupting the intergenerational transfer of healthy child-rearing practices. Over time, these experiences contributing to a lack of preparedness for family life and parenting (Roy, 2014). In some cases, the adverse and at times inhumane conditions encountered within these settings inculcated a host of negative behaviors (Horejsi et al., 1992). Although the majority of Indigenous parents were able to transcend their harsh upbringing and became effective parents, some struggled with parenting their own children. In a qualitative study with a mixed sample of 22 American Indians who attended boarding school and second generation offspring, Chase (2012) revealed that participants who were exposed to harsh child-rearing practices either at the boarding school or at home experienced continued difficulties with trust, communication, relationships, and parenting. Fast and Collin-Vézina (2010) highlighted the risk of this cycle of impaired parenting being sustained into the future until children have caregivers who model nurturing care. Furthermore, the government's policies of forced removal of children from AIAN and Indigenous families and communities promoted a false belief that AIAN families were not appropriate to raise their children (Horejsi, et al., 1992). This message may have been internalized by AIAN families and instilled doubt about their traditional ways of parenting.

Some scholars have suggested that historical trauma may be responsible for the higher incidence of household dysfunction in AIAN and other Indigenous families, usually gauged through various indicators like domestic violence, child abuse and neglect, parental illicit drug use, criminal activity, and mental illness (Bombay et al., 2011; Cross et al., 2000). Brown-Rice (2013) also noted that historical trauma, particularly the grievances resulting from the boarding school era, may account for the over-representation of AIAN children in the United States foster care system. Bombay et al. (2011) found that First Nations adult children of parents who had attended the Indian residential schools in Canada (n=67) reported higher rates of adverse childhood experiences, such as emotional, physical, and sexual abuse, neglect, and household violence compared to individuals whose parents were non-attendees (n=76), which in turn predicted higher depressive symptoms. Similar abuses of children were reported by Catani and colleagues (Catani et al., 2008) in Afghanistan and Sri Lanka as a result of war and armed conflict. These household symptoms may also reflect the social malaises that ravage the social fabric of neighborhoods and communities affected by historical trauma. Community impacts of historical trauma are discussed in the next section.

Community Responses to Historical Trauma

Since the inception of the study of intergenerational trauma, collective responses have been overlooked as trauma experts paid greater attention to individual-level consequences (Evan-Campbell, 2008; Somasundaram, 2007, 2011, 2014). There is, in fact, little mention of community-wide impacts in the trauma literature. It was only in the last two decades that scholars started to acknowledge that historically traumatic events can have debilitating effects on communities at large. Evans-Campbell (2008) argued that despite the fact that community-level impacts are less understood, their implications are the most insidious because they influence the

life course of entire communities and populations. Other authors noted that collectively experienced traumatic events follow a distinctive trajectory that differs from the effects of localized traumatic incidents (Abramowitz, 2005, Hoffman & Kruczek, 2011; Summerfield, 1999).

Prolonged or repetitive assaults on a population tear at the social fabric of its communities by disrupting social structures, processes, and functioning. Evans-Campbell (2008) explained how the onslaught of traumatic grievances endured by some AIAN communities left them in a weakened state, without operational institutions that could help them rebuild and thrive. In some communities, the resultant disarray led to a breakdown in social norms, morals, and values, and an erosion of communal trust (Catani et al., 2008, Commission for Historical Clarification, Somasundaram, 2007, 2014; Wesley-Esquimaux & Smolewski, 2004). Several researchers who investigated the collective impact of large-scale political violence in different populations, such as Indigenous groups (Faimon, 2004; Wesley-Esquimaux & Smolewski, 2004), Cambodia (Hinton, 2007), and Sri Lankans (Somasundaram, 2007), reported that the communities became distrustful and suspicious.

Additionally, extended cycles of subjugation and persecution engender an overarching sense of powerlessness that drives communities to become passive and more dependent (Somasundaram, 2007, 2014; Wesley-Esquimaux & Smolewski, 2004). Somasundaram (2007) noted that the Tamil communities "had learned to be silent, uninvolved and to stay in the background" (p. 14) as a consequence of the civil war in Sri Lanka. Communities and societies may also become engulfed in silence, shame, and guilt (Faimon, 2004; Lin et al., 2009; Ramos, 2013). Ramos (2013) highlighted the impregnable silence that hovered over communities in Guatemala where inhabitants seemed to be guided by an implicit understanding that the past

should not be discussed. Similarly, Faimon (2004) drew attention to the legacy of collective shame, guilt, and inferiority in Indigenous communities in Minnesota that can traced to the harrowing incidents surrounding the "Sioux Uprising" and the genocidal policies enacted by federal and state governments.

Disorganized or unstable leadership is another corollary of historical trauma in affected communities, usually caused by the loss of human capacity (Evans-Campbell, 2008; Somasundaram, 2007, 2014). Federal policies that sanctioned the forced removal of AIAN children from their homes to attend boarding schools or to be fostered or adopted by White families contributed to the loss of children in several AIAN communities (Evans-Campbell, 2008). The depletion in social capital not only endangered the future leadership of entire AIAN tribes, but also their ability to preserve their cultural legacy.

Loss of culture and cultural artifacts, such as traditional practices and language, represent another class of community-wide effects. The disruption in cultural continuity can seriously undermine a group's cultural identity, which is manifested by a devaluation of one's culture, a decline in cultural pride, and a loss of kinship with fellow cultural group members (Bombay et al., 2009). In Canada, First Nations communities that had low cultural continuity engaged in limited collective efforts to safeguard and reconstruct their cultural legacy such as pursuing land claims, reclaiming their rights of self-government, and setting up communal facilities that help preserve and promote their culture (Chandler & Lalonde, 1998). Adams (1995) argued that the assimilationist strategies implemented in American Indian boarding schools, whereby children were punished for speaking their Native language or practicing traditional rituals and religions, contributed to the loss of language and other traditional practices. Similarly, Nagata et al. (2015) reported that the Japanese American internment camps led to loss of culture among survivors.

Japanese Americans who were incarcerated felt compelled to downplay or renounce their Japanese ancestry, and to support their children's acculturation, in order to blend into the dominant American culture.

Also revealed in the literature is a growing recognition of the relationship between historical trauma and maladaptive behaviors, including higher rates of suicide, community violence, homicide, accidental deaths, domestic violence, child abuse, alcoholism and substance use, and risky health behaviors (Brave Heart & DeBruyn, 1998; Duran & Duran, 1995). Tribal elders from two reservations in the upper Midwest imputed the higher rates of alcoholism and child abuse in their communities to the historical losses and wounding (Whitbeck, Adams, et al., 2004). In another study, Whitbeck, Chen, et al. (2004) found that historical loss mediated the impact of perceived discrimination on 12-month alcohol abuse among American Indian women. These destructive behavior patterns mobilize intergenerational cycles of trauma and violence (DeBruyn et al., 2001; Manson et al., 2005) and reflect internalized oppression and racism (Brave Heart & DeBruyn, 1998). Freire (1980/1996) characterized internalized oppression as the internalization of the perpetrator's views in response to persistent systemic oppression, which results in anger, aggression, and hatred inflicted on oneself and members of one's own group. In some cases, hatred and violent behavior are directed at the perpetrating group, thereby fueling future hostilities as evidenced by the ongoing Israeli-Palestinian conflict and the war in Bosnia (Barron & Abdallah, 2013; Volkan, 2009).

The lasting effects of historical trauma at the community level also can be manifested as socio-economic disparities and material dispossession. Some scholars have drawn attention to the disproportionate poverty, high unemployment rates, and diminished living standards that pervade some communities affected by historical trauma (Adonis, 2016, Bombay et al., 2009,

Brown-Rice, 2013). In a study on the intergenerational impact of the Apartheid era on the contemporary generations, the participants explained how the loss of breadwinners compromised the survival of entire families and brought about financial and material hardships across generations (Adonis, 2016). The forced relocation of as many as 100,000 AIAN to reservations or urban settings following massive confiscation of lands by the United States government (Plous, 2003) partly accounts for the disproportionate poverty and social challenges afflicting several AIAN communities today (Denny et al., 2005; Indian Health Service, 2019; Sarche & Spicer, 2008). Likewise, following the abolition of slavery in the United States, there were no reparations or attempts to redistribute land to African Americans (Cross, 1998). Instead, many states, especially in the South, upheld public policies and laws ("separate but equal") whose primary aim was the systematic underdevelopment of Black citizens in terms of housing and educational and employment opportunities. These socio-economic patterns concur with the tenets of social reproduction theory, which postulates that younger generations have a higher chance to occupy a similar socio-economic position as their parents due to societal structures that perpetuate social inequality from one generation to the next (Blackburn & Prandy, 1997).

Unpacking the multilevel effects of historical trauma enables mental health practitioners to understand the extent of the impact of mass violence, subjugation, and oppression on targeted populations. It is especially important because history is often relayed in piecemeal fashion rather than as a coherent story with a social trajectory (Evans-Campbell, 2008). With regard to the present study, recognizing the collective impacts of historical trauma, rather than focusing exclusively on individual manifestations, helps inform the strategies and interventions that mental health practitioners can implement to redress the harms of historical trauma at the community and society levels.

Variability in Responses to Historical Trauma and Resilience

Current models of psychological trauma tend to highlight the negative outcomes of traumatic incidents (Evans-Campbell, 2008). Only recently have trauma scholars started shifting their attention to the study of how people recover and restore their well-being in the wake of traumatic experiences. The concept of historical trauma is grounded in psychological trauma literature; therefore, most of the scholarship in this area has revolved around the adverse behavioral health impacts on the descendants of primary survivors, their families, and communities at large (Gone, 2013). This emphasis must not overshadow the other face of trauma, meaning the resilience and growth that can flow from some of humanity's deepest wounds.

Some authors have argued that historical trauma could be simultaneously a potential source of distress and vulnerability and an opportunity to cultivate resilient traits and behaviors (Mohatt et al., 2014; Novac & Hubert-Schneider, 1998). Wardi (1992) noted through her clinical observations that the children of traumatized Holocaust survivors either felt overwhelmed by the psychological burden cast upon them or developed psychological hardiness and resilience to manage their family challenges. Keinan and collegaues (Keinan et al., 1988) claimed that some of the offspring of Holocaust survivors developed remarkable coping skills to contend with their parents' traumatization. These observations concerning the offspring of Holocaust survivors were supported by other scholars who reported psychological adjustment and resilience and among the descendants of other traumatized populations (Crawford, 2013; Cross, 1998; Denham, 2008). Cross (1998) claimed that many African Americans who were freed from bondage and their offspring constructed lives that celebrated close family and community connections. Similarly, Evan-Campbell (2008) explained that historical legacy of subjugation prompted many

indigenous communities to preserve community ties and their cultural heritage. These findings attest to the wide variability in responses witnessed in groups affected by historically traumatic events; however, further scholarship on healing and resilience in the context of historical trauma is needed.

Additionally, it is important to clarify why some descendants continue to display profound symptomatology, whereas others are able to transcend their ancestors' traumatic legacy. More empirical research is required to account for the variability in responses by investigating factors that mitigate the impact of historical trauma and promote resilience in individuals, families, and communities (Adonis, 2016). In trauma literature, multiple factors have been linked with promoting resilience, including age, gender, education, and individual traits such as temperament and coping methods (Bonanno & Mancini, 2008); parenting practices and communication styles (Gewirtz et al, 2008; Sorscher & Cohen, 1997); and family and community support (Landau et al., 2008). In terms of the present study, it is important to take into consideration those factors that foster healing, growth, and resilience when designing and delivering psychosocial interventions in groups affected by historical trauma. Some of those factors can be addressed and supported through culturally-sensitive tailored interventions. In the next section, individual and family interventions for historical trauma will be presented and discussed followed by community- and society-level interventions.

Psychosocial Interventions for Historical Trauma

The field of traumatology has grown exponentially in the last few decades, drawing significant clinical and research attention on the subject, as more human lives across the globe continue to bear the brunt of diverse traumatic events and their aftermath (López-Zerón & Parra-Cardona, 2015). This progress can be largely attributed to large-scale studies in the United

States, such as the *National Epidemiological Study* (Kessler et al., 1999) and the *Women, Co-Occurring Disorders, and Violence* study (SAMHSA, 2007), which exposed the prevalence and salience of trauma in people's lives and galvanized interest in trauma-informed care among behavioral health practitioners (SAMHSA, 2014). The lobbying for the integration of trauma-informed care in behavioral health services, as well as the growing pressure by government and funding institutions and insurance companies for evidence-based treatments and therapies have inspired new directions and innovations in trauma intervention (Perry, 2013). Although the marked progress in trauma rehabilitation deserves credit, it is important to note that this advancement has not been consistent across the board. There is a lack of empirically supported trauma interventions that address the intergenerational sequelae of historical trauma and evince cultural sensitivity. Empirical literature on historical trauma interventions to date is limited and fragmented. Recent developments in this area are the outcome of scholarship led by Indigenous scholars.

Traditionally, the goal of trauma interventions has been to identify and allay PTSD symptomatology and other trauma-related manifestations at the individual level (Hart, 2009; López-Zerón & Parra-Cardona, 2015). This narrow focus is a by-product of the dominant Western treatment paradigm that tends to pathologize distress (Brave Heart, 2003; Brave Heart & DeBruyn, 1998; Duran, 2006), and allied publications like the DSM that facilitate the assessment, diagnosis, and treatment of traumatic stress by means of useful yet reductive criteria (Perry, 2013). The limited scope of current trauma interventions makes them unsuitable to address the complex and subtle nature of historical trauma and its multilevel impacts on affected populations, such as ecosystemic factors that shape the public context where individuals experience trauma (e.g., the history of systemic oppression, socioeconomic, political, and

cultural elements) and the consequences of unconventional sources of trauma (e.g., discrimination, daily microaggressions). Additionally, trauma interventions based on the Eurocentric model of health and illness revolve around the individual and intrapsychic effects of trauma, and therefore they tend to overlook the impact of trauma on families and communities (López-Zerón & Parra-Cardona, 2015). An individualized approach to treatment is inadequate on several counts. First, historical trauma is both an individual and a communal response to historical atrocities that continue to be perpetuated by present-day injustices and structural violence. Second, an individual therapeutic focus conflicts with non-Western collectivist worldviews and values that place greater emphasis on the needs of the community over the individual (de Jong, 2011; Somasundaram, 2014). Furthermore, it is not viable, if not impossible, to work with all the members of a culture affected by trauma (Hoffman & Kruczek, 2011). Lastly, mass traumatic events necessitate the rehabilitation of the social context that may harbor elements of the trauma and continue to traumatize survivors and future generations (Somasundaram, 2014; Sotero, 2006).

The over-reliance on empirical evidence based on randomized controlled trials and quantitative designs to validate the efficacy of trauma-focused interventions is another offshoot of the ironclad loyalty to Western values (Perry, 2013). Such an approach, although beneficial to develop reliable evidence-based treatment formulations for individuals coping with trauma, discounts unorthodox, culture-centered approaches to therapy and research that do not align precisely with the normative, empirical standards imposed by the medicalized Western paradigm. The strict adherence to empiricism limits the range of effective, culturally-responsive interventions that can address the ancestral trauma passed down through the generations (Perry,

2013). Widely used, evidence-based individual trauma interventions will be discussed next as well as interventions that explicitly target intergenerational trauma.

Individual Interventions

Heightened clinical and scientific interest in trauma gave rise to a wide spectrum of individual intervention models designed to treat trauma-related symptoms, traumatic stress disorders, and co-occurring conditions, such as substance abuse and depression. Salient individual trauma interventions that have been empirically supported for their efficacy include cognitive behavior therapies, exposure therapy, eye movement desensitization and reprocessing, and pharmacological therapy (Jennings, 2004, 2008; SAMHSA, 2014).

Cognitive Behavior Therapies

Cognitive behavior therapies (CBTs) are based on the premise that an individual's thoughts mediate the relationship between situational demands and an individual's attempts to respond to those external cues. They integrate cognitive and behavior theories to reduce and resolve distress symptoms by altering conditioned patterns of thinking and behavior (SAMHSA, 2014). Since the 1970s when CBT was developed by Aaron Beck (1976), it has expanded into several modalities and has been widely and effectively used with children and adult populations affected by anxiety, depression, substance abuse, and personality disorders (SAMHA, 2014). CBT has also been successfully applied to the treatment of trauma and PTSD in different populations, including survivors of: childhood sexual abuse (McDonagh et al., 2005), domestic violence (Johnson et al., 2011), sexual assault (Foa et al., 2006); motor vehicle accidents (Beck et al., 2009), natural disaster (Hamblen et al., 2009), civil conflicts and terrorism (Duffy et al., 2007; Levitt et al., 2007), refugees and asylum seekers refugees/asylum seekers (Hinton et al., 2009; Paunovic & Öst, 2001), and combat veterans (Kent et al., 2011).

Trauma-focused cognitive behavior therapy (TF-CBT) is an adaptation of CBT that is intended to relieve emotional and behavioral difficulties, by challenging problematic trauma-related cognitions (Cahill et al., 2009). TF-CBT can encompass different techniques and modalities. Cahill and colleagues (Cahill et al., 2009), in their review of TF-CBT, identified seven intervention modalities, including acceptance and commitment therapy (ACT), cognitive processing therapy (CPT), cognitive therapy (CT), dialectical behavior therapy (DBT), exposure therapy, relaxation training, and stress inoculation training. These treatment modalities emphasize unique therapeutic outcomes despite several overlaps. CPT supports clients to address problematic beliefs about the traumatic experience(s) such as self-blame, and thus shares some similarities with CT which seeks to modify dysfunctional thinking patterns and cognitive distortions, whereas relaxation training is a behavioral approach that promotes relaxation techniques to ease stress and anxiety.

CBT and TF-CBT are widely accepted and well-researched approaches in the treatment of trauma. Additionally, both CBT and TF-CBT have been successfully adapted with diverse populations (e.g. Latinas, Vietnamese, and Cambodians) and for application in group interventions (SAMHSA, 2014). A number of review studies have been conducted to determine the efficacy of CBT in treating trauma and PTSD (Cahill et al., 2009; Kar, 2011; Mendes et al., 2008), which supported its effectiveness as a trauma intervention. Additionally, CBT has been successfully applied with clients with PTSD and various co-occurring disorders, such as panic disorder, major depression, bipolar disorder, schizophrenia, and substance use disorders (SAMHSA, 2014). Finally, there is promising evidence suggesting that CBT can be used to promote resilience and inner strength. In a pilot study that evaluated a resilience-focused CBT

intervention with 39 veterans with PTSD, Kent and colleagues (2011) reported improvements in affective symptoms, emotional health, memory, and executive functioning.

Exposure Therapy

In trauma-focused exposure therapy (ET), clients explore trauma-related material (e.g., memories, objects, feelings) through in vivo exposure or exposure through imagery (SAMHSA, 2014). Gradual and repeated exposures to reminders of the traumatic experience(s) result in desensitization and a reduction in emotional distress over time. ET can be delivered as a stand-alone intervention or as a component of TF-CBT, and it has been cataloged as a recommended treatment for PTSD in several treatment guidelines, such as the U.S. Department of Veterans Affairs and the Institute of Medicine (SAMHSA, 2014). ET is typically prescribed as a first-line treatment option when the principal trauma manifestations are intrusive thoughts, flashbacks, trauma-induced fears, panic attacks, and avoidance behaviors.

Prolonged exposure (PE) is a specific modality of ET that has received a lot of attention and has been widely researched (SAMHSA, 2014). McLean and Foa (2011) reviewed 25 randomized controlled trials using PE and established that PE is effective in reducing PTSD. Some of studies included in the review supported the efficacy of PE for both acute and chronic PTSD and reported large effects sizes, rapid results, and therapeutic outcomes that persists for one year and beyond. Powers and colleagues (Powers et al., 2010) reached similar conclusions in a meta-analysis of PE and noted that PE is as effective as other trauma interventions, such as CBT and eye movement desensitization and reprocessing. In another meta-analysis study, Ougrin (2011) also reported no significant differences in effectiveness between PE and CBT.

The effectiveness of PE has also been established with different client populations, including male and female combat veterans (Schnurr et al., 2007; Yoder et al., 2012), female

rape survivors (Resick et al., 2012), women who were victims of childhood sexual abuse (McDonagh et al., 2005), survivors of terrorist attacks (Schneier et al., 2012), and refugees who witnessed political violence (Paunovic & Öst, 2001). Also, ET can be delivered effectively in groups (Ready et al., 2008). Some researchers have raised concerns about the applicability of ET to traumatized individuals from non-Western cultures (Hinton et al., 2012), although the evidence in this area is not conclusive. Hinton and colleagues (2012) suggested taking a more phased approach and using imagery and techniques derived from the clients' cultural traditions when applying PE with non-Western clients.

The unpalatable nature of PE and its potential to worsen symptoms for some clients, at least in the early stages of treatment, have also generated some resistance to its use as a trauma intervention (SAMHSA, 2014). However, Cahill et al. (2006) reviewed studies on dropout rates and worsening of symptoms in the context of ET for PTSD, and found that the dropout rates and worsening of symptoms for ET were comparable to the data for other treatments. However, worsening of symptoms was significantly lower in participants in the ET interventions than in non-treatment controls. Promising directions in ET include the use of virtual reality software to facilitate controlled and more realistic exposure experiences (Alcañiz et al., 2004), and combining PE with narrative therapy (Robjant & Fazel, 2010).

Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) is a trauma-specific intervention that helps clients process traumatic and adverse life experiences (Shapiro, 2001). In EMDR therapy, directed lateral eye movements and/or other rhythmic stimulation (e.g., sounds, taps) are used to desensitize clients to traumatic memories. External stimulation helps decrease emotional distress, lower physiological arousal, and alter distressing thoughts. EMDR draws

upon a host of theoretical frameworks, including information processing, CBT, and psychoneurology, and CBT. EMDR is accepted as an effective, evidence-based treatment for PTSD by various institutions, such as the U.S. Department of Veterans Affairs, the International Society for Traumatic Stress Studies, the Royal College of Psychiatrists, the British National Institute for Health and Clinical Excellence, and the Australian Centre for Posttraumatic Mental Health. SAMHSA's National Registry of Effective Evidence-Based Programs and Practices also recognizes EMDR as effective treatment for PTSD, anxiety, and depressive symptoms (SAMHSA, 2014).

A number of systematic reviews and meta-analyses have supported EMDR's effectiveness in alleviating PTSD symptoms (Mills et al., 2012; Spates et al., 2009), however, with the caveat that the eye movement component of the intervention was not necessary for the treatment to be effective (Ehlers et al., 2010). Davidson and Parker (2001) reached a similar conclusion in an earlier meta-analysis of EMDR, finding no additional benefits when EMDR was practiced with the eye movements compared with when it was practiced without them. Spates et al. (2009), in their review, concluded that EMDR and ET are equally effective treatment approaches. There is limited evidence on the applicability of EMDR to clients from culturally diverse backgrounds (Perry, 2013).

Pharmacological Therapy

Pharmacological therapy, also known as pharmacotherapy, involves the prescription of medication to alleviate trauma-related symptoms. Certain medications, such as selective serotonin reuptake inhibitors (SSRIs) reduce autonomic arousal, which enables individuals to gain emotional distance from traumatic intrusions (van der Kolk, 2003). Although pharmacological therapy has been recommended as a potential treatment for PTSD in several

treatment guidelines, it has been argued that it should be part of a comprehensive treatment plan and not used as a first line treatment (SAMHSA, 2014). Several review studies evaluated the efficacy of a variety of drugs, including SSRIs, serotonin norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants, monoamine oxidase inhibitors (MAOs), and atypical antipsychotics such as risperidone (Friedman & Davidson, 2007; Ipser & Stein, 2011; Ravindran & Stein, 2009). A number of reviews indicated that SSRIs are the most popular and researched, and have been found effective in reducing PTSD symptomatology and the likelihood of relapse following remission in numerous randomized controlled trials (Ravindran & Stein, 2009; Stein et al., 2009). Atypical antipsychotics, such as risperidone, have been found effective for clients with PTSD who do not respond to SSRI (Berger et al., 2009).

Although several reviews confirmed the efficacy of pharmacotherapy in the treatment of PTSD, not all reviews supported this conclusion. The Institute of Medicine (2008) reported that there was not enough evidence to determine the effectiveness of the medications evaluated in their review in treating PTSD. In response to this finding, Ravindran and Stein (2009) argued that efficacy of certain medications can vary considerably among individuals; however, this does not mean that they should be dismissed. More empirical research is needed to compare the effectiveness of combination therapy (pharmacotherapy and psychotherapy) against pharmacotherapy or psychotherapy alone, and to determine the effects of culture on the treatment outcomes of medications for PTSD (SAMHSA, 2014).

Other Promising Approaches

All the intervention approaches described above, CBTs, ET, EMDR and psychopharmacology, enjoy robust empirical support (Jennings, 2008; SAMHSA, 2014), however this does not mean that they are appropriate to facilitate the healing of historical trauma. Interventions using ET and

EMDR are more suited to address traumatic incidents that are more specific and contained. Furthermore, the success of these therapies should not undermine the effectiveness of other trauma intervention models. Narrative therapy, DBT, ACT, mindfulness-based therapy, and imagery-based treatments are considered promising emerging therapeutic interventions for trauma and PTSD (SAMHSA, 2014). However, these interventions require further research to confirm their efficacy. Narrative therapy was applied for the treatment of trauma and PTSD stemming from political or community violence (Neuner et al., 2002, 2004). Historical trauma scholars might consider exploring the use of narrative therapy for historical trauma. The use of narratives in therapy enables clients to connect events in their lives, gain insight into their behavioral responses to trauma-related reminders, and develop knowledge and skills to cope with emotional distress and replace unproductive behavioral patterns (SAMHSA, 2014). These therapeutic goals are congruent with the phenomenon of historical trauma. Additionally, narrative therapy may be more relevant for clients from cultures that have oral-based traditions (Perry, 2013).

Finally, caution must be exercised when determining the efficacy of extant trauma interventions as not all therapeutic benefits can be empirically quantified and assessed. Psychodynamic therapies were found to be relatively ineffective in PTSD treatment by most review studies and meta-analyses (SAMHSA, 2014). However, Schottenbauer et al. (2008) in a review of research on psychodynamic therapy for PTSD, contested the inferences made by previous reviews that focused on limited outcomes. The authors argued that the benefits of psychodynamic approaches are typically not evaluated in the research, such as improved self-esteem and social functioning. Schottenbauer et al. (2008) also discussed how to best apply psychodynamic therapy with clients who have PTSD, especially those with complex PTSD.

Similar conclusions were reached by Kudler and colleagues (Kudler et al., 2009) in another review study on the use of psychodynamic therapy in the treatment of PTSD. They suggested that psychodynamic therapy may not be advisable for every client affected by trauma and offered guidelines for determining which clients are best suited for this treatment approach. Psychodynamic therapy has been specifically used with clients affected by historical trauma, particularly with descendants of Holocaust survivors. Psychodynamic therapy and the transgenerational trauma and resilience genogram (Goodman, 2013) are discussed in the next part of this section

Psychodynamic Therapy. Psychological trauma and its adverse impact on the human psyche constitute a central theme in psychoanalytic literature. The Jewish Holocaust had a profound influence on psychoanalytic thinking on trauma (Connolly, 2011). Psychoanalytic theorists posited that extreme traumatic events that are prolonged, deliberately inflicted, and result in extensive destruction, can create a rupture at the core of a person's psyche, which develops into an intrapsychic abyss that cannot accommodate any representation of the traumatic experience. Laub and Auerhahn (1993) described this void or emptiness as "the collapse of the imaginative capacity to visualize atrocity" (p.288), which generates an impregnable disorientation in the survivors. Laub and Podell (1995) suggested that massive traumatic experiences destroy the empathic bond that connects individuals with the rest of the human community. The disconnection or dissociation can be so severe that individuals become indifferent to their own survival and the world around them. The groundbreaking work of Kestenberg (1982) exposed the psychological consequences of the Holocaust in second-generation survivors. Her findings helped to generate interest in the subject of intergenerational

trauma among psychoanalysts, who began to explore ways to work analytically with this population and the children of survivors of other repressive regimes.

Several psychoanalytic thinkers argued that the survivor's inability to remember, symbolize, and mourn the tragedy lies at the heart of the intergenerational transmission of trauma (Connolly, 2011; Markman, 2010). Unprocessed psychic elements are then passed onto the offspring (Connolly, 2011). In primary survivors and their children, the trauma is represented as the death of time and the death of language. The death of time refers to a temporal discontinuity between past, present, and future, also known as a "time tunnel" (Kestenberg, 1982, p.86) or "telescoping of generations" (Faimberg, 1988, p. 99). The offspring are trapped in a timeless past that cannot be claimed as their own because it belongs to their parents, and thus they are unable to link it with their present. The death of time creates a dissociation between the subjective time of memory and the objective time of history, which undermines the capacity to create meaningful narratives essential to establish a sense of identity (Connolly, 2011). The death of language represents the inability to think imaginatively and construct meaningful narratives beyond the shadows of the incomprehensible horrors and senseless brutality of the Holocaust and similar traumatic events. The death of language blights a person's ability to perform dream work which in itself is based on symbolization and metaphors (Connolly, 2011). This impairment is often manifested as sleep disturbances and nightmares which are also experienced by second-generation survivors, as if the offspring are bound to relive the nightmares of their parents.

Connolly (2011) claimed that the death of time and language undermine a person's ability to create meaningful narratives. Narratives can only be meaningful and promote healing so long as they can establish a dialogical relationship with oneself and others in the present. She

argued that in psychoanalytic therapy with survivors and their children, the clinician must go beyond the analysis of transference and countertransference dynamics in the here and now, which can be counterproductive. Connolly (2011) explained that the focus should be on recreating the empathic bond between the therapist and the client which enables the reconstruction of time and language. In therapy, the psychoanalyst assumes the role of the "witnessing other" who is willing to partake in the intense emotions evoked by the ghastly reality of the traumatic experience, without losing the capacity for hope and the ability to manipulate the images metaphorically. The openness and receptivity of the therapist create a safe space for the client to engage in representation. In order to be a "witnessing other" the therapist must resist the temptation to deny and defend themselves against the menacing evil implied by the client's tragic experiences.

Gerlach (2011) argued that, in psychoanalysis, second-generation offspring must be helped to break the circular time loop in which they are entrapped so that they can move from mindless identification with their parents' trauma to conscious representation of their painful generational legacy. Geralch also drew attention to the endurance of the therapists to withstand intense feelings of rage, guilt, sadness, hatred and grief to help clients integrate the rejected parts of their identity. Similarly, Fonagy (1999) stated that an essential component of rehabilitative change in psychotherapy is the attachment relationship between the client and the therapist, which recreates the child-caregiver bond. The representation of the client's dissociated mental states is made possible through the words and gestures of the therapist, much like infants understand themselves through the actions of their caregiver.

Transgenerational Trauma and Resilience Genogram. The transgenerational trauma and resilience genogram (TTRG) was proposed by Goodman (2013) and it is a holistic

therapeutic framework and intervention approach that explicitly addresses the intergenerational transmission of trauma. The TTRG model rests upon the application of the genogram to examine complex family and psychological patterns across multiple generations, including transgenerational trauma. This intervention model also adopts an ecological systems perspective to the understanding, assessment, and treatment trauma, based on Bronfenbrenner's (1977) ecological model. It attends to ecosystemic factors, including the cultural and sociopolitical conditions that impact individual experience and recovery from trauma, as well as elements that promote resilience following trauma. An ecosystemic view helps illuminate how contemporary and historical traumas intersect, particularly for historically oppressed and marginalized populations.

A key contribution of the TTRG model is that it can be used as an assessment tool to assist professionals in conducting comprehensive, culturally sensitive trauma assessments (Goodman, 2013). Thus, the model addresses a major challenge that has hindered progress in the field of historical trauma since its inception, the lack of structured measures to assess for historical trauma. Furthermore, the TTRG can be used as an intervention approach to work with clients affected by historical trauma (Goodman, 2013). The TTRG provides a culturally responsive and strengths-based framework for working with clients, which is steeped in a social justice philosophy. It is culturally relevant because it is client-centered and "reflects the personal, familial, cultural, and communal experiences of the client" (Goodman, 2013, p. 393). The TTRG model also highlights the transmission of strengths and adaptive coping strategies instead of focusing solely on maladaptive patterns, and draws upon the sources of resilience at the individual, family, and community levels. It has a social justice orientation in that it helps to deconstruct different forms and layers of oppression that converge with trauma and to raise the

client's awareness of these factors. Lastly the model can be used with individuals, families, and groups in the community. Despite the myriad strengths of the TTRG model, there is no empirical evidence to date supporting its efficacy in helping individuals heal from historical trauma.

Family and Couple Interventions

Trauma and traumatic stress are likely to affect relationships with significant others, including the survivor's family (Erbes, 2011; SAMHSA, 2014). Despite the limited research on the effectiveness of family therapy with trauma survivors, a few review studies indicated that family and couple therapy can be a helpful second-line intervention supporting the recovery process of individuals with PTSD (Cukor et al., 2009; Sherman et al., 2005). Riggs et al. (2009), in their review of various family and couples therapy approaches, observed that most family and couples interventions attempt to redress the disruptions in the family unit and family relationships. Additionally, family members may experience secondary traumatization, have their own histories of trauma, or lack knowledge of trauma symptoms and treatment, which may interfere with the support they provide to the trauma survivor (SAMHSA, 2014). Certain traumatic events can result in more than one family member being affected by the trauma.

A range of couple and family therapies address traumatic stress and PTSD, but few empirical studies exist that confirm or dispute their value (SAMHSA, 2014). Additionally, there is limited research that compares the effectiveness of different approaches to family and couples therapy for trauma and PTSD. Riggs et al. (2009) reviewed several modalities of family interventions, including behavioral family and couples therapy, cognitive-behavioral couples' therapy, lifestyle management courses, emotionally focused couple therapy, spousal education and support programs, family systems-based therapy, and critical interaction therapy. The

researchers concluded that there is strong evidence supporting the efficacy of behavioral family and couples therapy, relatively weaker support for cognitive-behavioral couples' therapy, and low to no support for the other types of interventions included in the review. There is preliminary evidence that structured approach therapy, a couple-based treatment modality, may be helpful in reducing overall PTSD severity, avoidance behaviors, and emotional numbing (Sautter et al., 2011).

Family interventions may be more culturally appropriate for clients from collectivist cultures. Weine et al. (2008) highlighted the benefits of interventions with multiple family groups for refugees with PTSD, such as increasing participation and engagement in mental health services in this population. However, none of the family interventions described above have been applied and evaluated for historical trauma.

The Intergenerational Trauma Treatment Model

The intergenerational trauma treatment model (ITTM) is a manualized intervention designed to mitigate the adverse impact of chronic and complex childhood trauma on children's development (Copping, 1996; Copping et al., 2001, Scott & Copping, 2008). The model is similar to other childhood trauma interventions, such as the Real Life Heroes and the Assessment-Based Treatment for Traumatized Children: Pathway Model, in that it incorporates elements from traditional trauma interventions, including trauma exposure, cognitive behavioral strategies, stress management, and parent education (Scott & Copping, 2008). However, the model is unique because it targets parents as the primary agents of change in their children's lives and takes into account the intergenerational patterns of trauma transmission. The overarching goal of the ITTM is to promote the parent's capacity and confidence to support their children through trauma. Although the model is not intended as an intervention for families

affected by historical trauma, its focus on parents and intergenerational dynamics makes it a potential approach that may be considered in the future.

The ITTM targets parents of children between the ages of 3 and 18 (Scott and Copping, 2008). It is made up of 21 sessions and treatment is offered in three phases. The first phase entails psychoeducational group sessions for parents, designed to help caregivers be more knowledgeable about childhood trauma, have greater awareness of their involvement in their child's trauma, learn strategies for better emotional regulation, and develop self-efficacy and motivation for change. The second phase consists of individual sessions with parents to address parental trauma. During this phase, intergenerational patterns of trauma transmission are explored, and caregivers reflect on how their own trauma might be impacting their child's life through behavioral responses that perpetuate trauma in the family. The third phase consists of therapeutic sessions for the child in the presence of the caregiver. The purpose of these latter sessions is to alleviate the child's trauma-related behaviors and symptoms and strengthen the parent-child relationship. During these sessions, the caregiver is a co-lead in the treatment, supporting the child to make constructive changes in their behavior and belief system. In a pre-post study, Copping et al. (2001) found that participating parents and children who underwent the ITTM intervention reported a reduction in child conduct disorder, relational problems, and caregiver depressive symptoms. However, more empirical research is required to determine the efficacy of this intervention model.

Group Interventions

An increasing variety of group trauma interventions is available (Jennings, 2004, 2008; SAMHSA, 2014). Ford et al. (2009) stated that group interventions may be particularly helpful for clients with PTSD who tend to isolate and disengage from others. Shea and colleagues (Shea

et al., 2009), however, found no evidence that group therapy is any more or less effective than individual interventions

Some of the individual interventions presented earlier in this chapter, including CBT and ET, can be delivered in a group format (SAMHSA, 2014). Several group trauma interventions are integrated approaches, meaning that they address traumatic stress and PTSD and at least one comorbid psychiatric condition, such as substance abuse and depression. A few group treatments have been evaluated for their effectiveness in helping individuals with PTSD and a history of trauma, however more research is needed to establish the value of these group trauma interventions. It is beyond the scope of this literature review to present and discuss all of the existing group trauma interventions; only a few evidenced-based group interventions are examined in this section.

Group trauma interventions are typically organized by type of trauma (SAMHSA, 2014), such as combat trauma (Schnurr et al., 2003) or political violence (Kira et al., 2012). In some cases, homogeneity in clients' backgrounds is critical for trauma-related reasons, such as exploration of sensitive or taboo topics as in the case of sexual violence or childhood sexual abuse (Classen et al., 2001; Lynch, 2011), or intergroup conflicts as in the case of groups for refugees (Kira et al., 2012).

A number of reviews of studies on group therapy for individuals with PTSD indicated no significant differences between trauma-focused intervention groups and present-centered or interpersonal/process groups (Bisson & Andrew, 2009; Shea et al., 2009). Shea and colleagues, (2009) observed that cognitive-behavioral group therapy, which was evaluated with combat veterans and adult survivors of sexual abuse, was as effective as present-centered group therapy in promoting improvements in a number of PTSD symptom measures. Similar findings were

reported by Bisson and Andrew (2009) who noted that the treatment outcomes of trauma-focused CBT groups were not significantly different from the outcomes of non-trauma focused CBT groups. However, in two separate studies, participants enrolled in the trauma-focused CBT groups reported more improvements in avoidance/numbing and hyperarousal (Schnurr et al., 2003) and anger (Classen et al., 2011) than participants in the present-centered groups.

Integrated Models

Trauma and PTSD are usually accompanied by substance use and other mental disorders. Consequently, clients seeking treatment for PTSD may require additional treatment to address the co-occurring condition(s) (SAMHSA, 2014). Integrated treatment approaches address multiple presenting problems. Most of the available integrated interventions address substance use issues. Examples of such integrated programs that address trauma and substance abuse are the Addictions and Trauma Recovery Integration Model, Transcend, Assisted Recovery Trauma and Substances, Helping Women Recover, Trauma Recovery and Empowerment Model, and Seeking Safety (SAMHSA, 2014).

Empirical research on integrated treatment models is limited; however, extant studies and reviews suggest that they effectively reduce PTSD symptomatology, substance abuse, and symptoms related to other psychiatric conditions (Dass-Brailsford & Myrick, 2010; Nixon & Nearmy, 2011). Dass-Brailsford and Myrick (2010) noted that there is a lack of research that evaluates and compares the treatment outcomes of different integrated models. Additionally, there is no conclusive evidence that confirms that integrated interventions are more effective than non-integrated ones (separate trauma-focused therapy and substance abuse interventions) (Hien et al., 2010; Torchalla et al., 2012).

Culture-Centered Interventions

Over the years, the demands for culture-centered approaches to treatment and healing have intensified. Bray (2010) highlighted the paradoxical tensions that exist in mental health service delivery. On the one hand, mental health is regarded as a peripheral concern by federal government in the United States, which is evidenced by budget cuts and decreased funding, whereas on the other hand, there is a renewed commitment to meet the needs of a culturally diverse population. Health care reforms and limited funding tend to tip the balance in favor of time-limited, cost-effective, and evidence-based treatment options. Such a leaning for empirically supported treatments not only dismisses the unique needs of ethnically diverse clients, but it undermines the possibility of implementing innovative interventions that promote indigenous healing modalities (Perry, 2013). It also forces a Western worldview upon cultural groups that subscribe to different values and beliefs. This hegemonic imposition of the Western lens on mental health continues to alienate, marginalize, and re-traumatize historically oppressed populations. In so doing, it implicitly reenacts the cycle of violence and subjugation through the same services that are intended to offer relief to traumatized individuals and communities.

It is therefore essential that decolonizing and culturally-responsive treatment formulations that have the potential to dismantle systemic and cultural oppression are funded, researched, and eventually incorporated into mainstream clinical practice to truly facilitate the healing of past and present wounds in contemporary and future generations. Several Indigenous researchers in North America (United States and Canada) have appeal for the removal of subjugative practices and the integration of Indigenous wisdom with Western knowledge and interventions (Brave Heart 2003; Gone, 2007, 2009; Gone & Alcántara, 2007). A similar message was communicated in the *United Nations Declaration on the Rights of Indigenous*

Peoples (United Nations, 2007). Historical trauma interventions developed for Indigenous populations are discussed in the next part of this section.

Indigenous Interventions

Many of the interventions that specifically address historical trauma and its consequences in affected populations have been developed by Indigenous scholars and behavioral health practitioners, and draw upon the wisdom of Indigenous cultures. Although most of these Indigenous interventions target individual-level factors, such as self-esteem and coping skills (Roy et al., 2015), they have a strong cultural and spiritual focus, and are more community-oriented than the majority of the interventions presented earlier in this chapter. However, this area of study is still at its infancy and there is a paucity of empirical research that systematically evaluates the effectiveness of these intervention models.

In Canada, the Aboriginal Healing Foundation (AHF) was set up in 1998 to promote and support the healing of individuals, families, and communities affected by the residential school system and its intergenerational impacts (Roy et al., 2015). Healing as defined by the AHF (2006) constitutes "a personal and societal recovery from the lasting effects of oppression and systemic racism experienced over generations" (p. 7). The AHF (2006) specified three key elements integral to effective healing programs: the infusion of Aboriginal values and worldviews across all stages of an intervention, including planning, design, and implementation; a safe and culturally welcoming healing environment; and culturally competent skilled healers.

The AHF (2006) further identified three intervention pillars that sustain a holistic healing strategy. The first pillar is reclaiming history, also known as legacy education, which represents interventions that help raise awareness of historical traumatic experiences (e.g., residential school experiences) and their impact on individuals, families and communities. This intervention

component enables individuals to conceptualize personal trauma as a shared experience within a social context. By facilitating the understanding of history, this pillar is a first step in the trauma recovery process (AHF, 2006). The second pillar is cultural interventions, which includes interventions that empower people to reconnect with their cultural heritage and traditions through storytelling and sharing of traditional knowledge, traditional ceremonies, language programs, and other activities. These experiences are intended to reinforce self-esteem, cultural identity, and a sense of belonging, aspects necessary to the healing process (AHF, 2006). The third pillar is therapeutic healing, which is the delivery of culturally-responsive holistic interventions that include a range of traditional therapies combined with Western-based therapies or alternative therapies. Traditional therapies are grounded in Aboriginal worldviews; they incorporate culturally-based healing strategies and keep individuals integrated within a collective.

Roy and colleagues (Roy et al., 2015), based on the AHF framework, conducted a scoping review of literature reporting interventions for Indigenous youth (ages 12-29 years) in Canada, the United States, Australia, and New Zealand that address historical trauma. These countries were selected because of their similar colonial histories. The authors identified 16 documented programs that met the inclusion criteria, which consisted of a mix of cultural interventions, interventions that used traditional and Western therapeutic approaches alone or combined, and interventions that included multiple components. Cultural interventions were typically characterized by traditional excursions, community gatherings, and activities that exposed youth to traditional ceremonies and practices. An earlier study by Davis-Berman (1989) supported the benefits of wilderness camps. The author reported that participation in the camps improved the youths' self-esteem, cultural pride, sense of belonging, and trust in relationships.

Most of the interventions included in Roy et al.'s (2015) review used a combination of traditional healing methods and Western therapeutic approach. One of the interventions that targeted alcohol use, adapted an existing 10-step program used in schools by including a talking circle and infusing into the sessions the concept of self-reliance, which is a central value in Cherokee community (Lowe, 2006). In another intervention that addressed trauma and PTSD, the interventionists modified the Cognitive Behavioral Intervention for Trauma in Schools model by reframing the content of the sessions to address traditional history, historical injustice and coping through community support (Goodkind et al., 2010). This intervention helped to address PTSD from an American Indian perspective. In another intervention, Veroff (2002) used art projects to encourage youth to explore their identity. The blending of Western therapies with Indigenous healing methods is consistent with the two-eyed seeing philosophy that recognizes the value of both Western and Indigenous ways of knowing in research and program development (Marsh et al., 2015). Other studies have investigated the integration of Western and traditional healing practices (Duran & Duran, 2000; Marsh et al., 2016; Thomas & Bellefeuille, 2006). Some of the reported beneficial outcomes of these blended interventions are increased self-esteem, improved sense of identity, cultural pride, feelings of belonging, and resolution of past trauma (Aboriginal Healing Foundation, 2003; Duran & Duran, 2000). Marsh et al. (2016) conducted a study that integrated Indigenous traditional healing practices and the Western treatment model Seeking Safety. The authors reported that participation in the intervention resulted in a reduction of historical trauma symptoms and substance use.

Roy et al. (2015), in their review, noted that only a few interventions incorporated a formal evaluation to assess the effectiveness of the programs. The authors emphasized the need to develop measures to assess the effectiveness of historical trauma interventions. A major

challenge in evaluation is balancing Western techniques and Aboriginal worldviews in order to identify suitable indicators of success that are appropriate for Indigenous communities. The authors suggested using a mixed- or multiple methods approach to evaluation in order to attend to Aboriginal worldviews and honor community perspectives and priorities. Finding a solution to assess treatment outcomes will also address some of the problems with funding agencies that often expect the use of instruments that assess for group-level outcomes (Roy et al., 2015). Another problem is developing measures to assess specifically for historical trauma on top of assessing for health and well-being issues related to historical trauma, such as substance use.

Several recommendations emerged from Roy et al.'s (2015) review, including the need to integrate Aboriginal worldviews into interventions and to strengthen cultural identity. Other suggestions were building autonomous and self-determining Aboriginal healing organizations, and integrating interventions into mainstream health services, with education of mainstream professionals about intergenerational trauma and issues in Aboriginal health and well-being. The authors also highlighted the need to directly address historical trauma through legacy education and the integration of historical trauma theory and concepts into the intervention design. They also stressed the importance of interventions that target changes within the community and larger society, and to support youth to become change agents in their environments. The next section addresses interventions that target systemic changes in communities and societies.

Community- and Society-Level Interventions

Research on community- and society-level interventions that address historical trauma is minimal despite the general acknowledgement of the need to enact systemic changes to stop the intergenerational cycles of violence and trauma. Literature in this area is mostly in the form of guidelines on how to deal with the proximate aftermath of collective traumatic events, and these

publications tend to be addressed to social workers (Shamai, 2016). Consequently, there is a dire need for empirical research that explores the functions, roles and types of interventions that mental health practitioners can engage in to support the healing of historical wounds.

Cultural continuity was identified as a protective factor against behavioral health problems at the community level (Chandler & Lalonde, 1998). Chandler and Lalonde, in a study with First Nations communities in Canada, found that communities that had higher cultural continuity had lower rates of youth suicide. Supporting cultural continuity and helping communities reconnect to their cultural heritage are promising avenues to promote resilience in communities affected by historical trauma. The authors identified several aspects of cultural continuity, including pursuing land claims, reclaiming rights of self-government, and setting up communal facilities that help preserve and promote culture. However, their work makes no reference to how mental health practitioners can support and empower communities to pursue these goals.

Educational healing programs that allow community members to understand the legacy of trauma across generations were also identified as helpful (Aboriginal Healing Foundation, 2003; Atkinson, 2002). These educational programs share the same goals of legacy education interventions discussed in the previous section. However, several authors argued that despite the value of these interventions in helping community members understand, confront, and release their suffering, they do not target the systemic factors that allow historical trauma to persist (Brave Heart, 2011; Roy et al., 2015). On the same lines, Silove and Steele (2006) highlighted the importance of repairing institutions and systems to create communal coherence. However, the literature on historical trauma offers little guidance on how mental health practitioners, including professional counselors, can go about promoting institutional and systemic changes.

Atkinson and colleagues underscored the importance of incorporating indigenous issues in the media, policy development, and academic institutions (Atkinson et al., 2014). Quinn (2007) offered similar suggestions to government bodies, professional associations, and academic institutions. Some of her suggestions are: allocating more funding to encourage and support the development of intervention programs that incorporate Indigenous healing practices; increasing awareness about Aboriginal issues through government-initiated awareness campaigns; organizing educational sessions about the legacy of colonization at professional conferences; offering training to mainstream health care providers in culturally-appropriate practices and interventions; introducing mandatory training in cultural competency in academic programs for mental health professionals; socializing mental health practitioners-in-training to the ongoing effects of colonization; and supporting collaborative research that utilizes a combination of Western and Indigenous decolonizing methodologies.

The transforming historical harms (THH) model (Hooker & Czajkowski, 2013) is a four-step framework that looks at both historical injustices and their present-day manifestations. The model, proposed by the Center for Justice and Peacebuilding at the Eastern Mennonite University, is built on four pillars: facing history, making connection, healing wounds, and taking action. All four dimensions apply different narrative approaches. Some of the narrative approaches for the sharing history pillar include sharing oral histories to increase public awareness, funding documentary film productions, exposing obscured historical narratives, and setting up truth commissions. Healing narratives may include individual therapy, support groups, rituals, public apologies, and public memorials. This model offers a comprehensive ecological approach to the healing of historical trauma that addresses individual and collective, historical and contemporary perspectives. Although the model is illustrated with several real-

world examples and suggestions, no empirical research has been conducted based on this THH framework. Additionally, it is unclear how mental health practitioners fit in some of the proposed interventions. It is in fact the purpose of the present study to shed light on how mental health practitioners respond to the challenges of historical trauma at the community and society levels and to explore the functions that counselors can assume in collective historical trauma interventions.

Chapter Summary

I opened this chapter with an overview of the concepts of psychological trauma, collective trauma, and cultural trauma, and their relationship to historical trauma. I then reviewed the literature on historical trauma, including an examination of mechanisms underlying the intergenerational transmission of trauma and the consequences of historical trauma at the individual, family, and community levels. In the last section, I discuss various individual, family, and collective interventions that can promote healing of historical wounds and disrupt the intergenerational cycle of trauma transmission.

CHAPTER III

METHODOLOGY

Collective interventions hold significant promise for mitigating the impact of historical grievances endured by populations exposed to long-term mass violence and oppression. In the present study, I investigated how mental health practitioners address historical trauma at the community and society levels, and explored the roles and functions that mental health counselors can assume in the delivery of collective historical trauma interventions. Drawing on a constructivist research paradigm, I adopted a qualitative research design and used constructivist grounded theory as the study's research methodology. Data was collected by means of intensive interviews that were carried out online using videoconferencing technology.

I start this chapter by reviewing the purpose of the study, and the research questions and objectives. Then, I provide a detailed description of the elected research design and methodology, including their suitability to address the research questions and their relevance to the philosophical underpinnings of the study. The sampling criteria and techniques, the recruitment procedures, data collection methods, and data analysis strategies are reviewed next. I conclude the chapter with a discussion of the implemented measures to enhance the rigor and quality of the study, and the relevant ethical considerations.

Purpose of the Study

The purpose of the study was to investigate how mental health practitioners address historical trauma at the community and society levels. Additionally, I explored the roles and functions that mental health counselors can assume in the delivery of collective historical trauma interventions. The bioecological model (Bronfenbrenner & Ceci, 1994) was used as a theoretical framework to contextualize the various systemic levels at which counselors and other mental

health practitioners can intervene to interrupt the intergenerational cycle of historical trauma from a collective perspective.

Research Questions

The study is guided by the following research questions:

- How do mental health practitioners address historical trauma at the community and society levels?
- What functions can mental health counselors assume in the delivery of collective historical trauma interventions?

Research Objectives

The research objectives informing the study are

- to explore different kinds of interventions undertaken by mental health practitioners to address historical trauma at community and society levels;
- to examine the strengths and limitations of these collective interventions;
- to identify innovative mental health approaches that can be used to address historical trauma from a collective perspective;
- to uncover how the cultural and sociopolitical contexts influence how mental health practitioners conduct collective historical trauma interventions
- to investigate how mental health practitioners engage with affected communities and populations when delivering collective historical trauma interventions;
- to explore how mental health practitioners interface with community leaders and professionals from other disciplines in the design and delivery of collective historical trauma interventions; and

- to examine the role that mental health counselors can play in the delivery of collective historical trauma interventions.

In line with the methodological precepts of grounded theory, the research questions and objectives were tentatively established at the beginning of the investigation to provide a preliminary focus to the inquiry (Charmaz, 2014; Glaser, 1978, 1992; Strauss & Corbin, 1998). Throughout the course of the study, I revisited the initial research questions to determine if they needed to be revised or fine-tuned to reflect the unfolding direction of the investigation and the emergent theoretical categories. During this review process, I made a minor revision to the second research question. The question initially read: "What functions *do* mental health counselors assume in the delivery of collective historical trauma interventions?" instead of, "What functions *can* mental health counselors assume in the delivery of collective historical trauma interventions?" Because of the limited representation of mental health counselors in the final study sample, I decided to rephrase the research question by replacing the verb "do" with "can" so that the question would be more congruent with the nature of the collected data and the professional identity of the respondents.

Research Paradigm

The study was situated within a constructivist theoretical orientation. Constructivism, also known as interpretivism, posits that reality is socially constructed, that is how people make sense of themselves and the world around them is a product of their interactions with their social surroundings (Lincoln & Guba, 1985). The constructivist paradigm incorporates a relativist ontology and a transactional/subjectivist epistemological perspective (Guba & Lincoln, 2005).

In relativism, it is assumed that there is no single observable social reality. Social reality is fluid, subjective, and multiply constructed and co-constructed in the minds of social actors

(Guba & Lincoln, 2005). Multiple realities that are socially and experientially located are presumed. A transactional/subjectivist epistemology postulates that knowledge is subjective, constructed through people's interactions with their physical and social environments, and mediated through shared signs and symbols that are recognized by members of a given culture (Grbich, 2013; Guba & Lincoln, 2005). Consequently, no objective knowledge exists independently of the knower. Within the constructivist paradigm, the artificial binary between ontology and epistemology becomes blurred because reality and knowledge alike are constructed in the minds of social actors (Lincoln et al., 2011).

In constructivist research, findings (knowledge) are co-created by the researcher and the researched who are interlocked in a transactional process, influencing each other (Guba & Lincoln, 2005). The goal of research grounded in the constructivist tradition is to reconstruct how people make sense of their lived experiences, actions, and behaviors, and how the social context situating their experiences shapes their constructed meanings (Grbich, 2013; Lincoln et al., 2011). These interpretations are then used to inform praxis.

A constructivist research paradigm was considered to be consistent with the purposes of the study. Constructivist inquiry is concerned with how individuals construe meaning based on their experiences. Similarly, in the study, I sought to illuminate how mental health practitioners, including counselors, made sense of their roles, responsibilities, and actions in relation to delivering interventions that address historical trauma at community and society levels. Additionally, the study was based on the assumption that every participant would have their unique understandings of the phenomenon under study, and that these idiosyncratic perspectives of reality are socially, culturally, and historically situated. In the next section, I present the research design of the study and the rationale for my methodological choices.

Research Design

In this section, I provide a description of the study design and research methodology. I also address the rationale for the chosen design and methodology in terms of their appropriateness to address the study's research questions. Based upon the philosophical tenets of constructivism, I applied a qualitative research design and used constructivist grounded theory as the research methodology (Charmaz, 2014).

Qualitative Inquiry

Denzin and Lincoln (2018) broadly defined qualitative research as "… an interpretive naturalistic approach to the world." (p. 10). Qualitative researchers study social phenomena in their natural settings. They are interested in how people interpret and make sense of their experiences of these phenomena. Unlike quantitative inquiry, which transforms complex data into numbers to draw inferences about the empirical world, qualitative research represents the phenomena under study using thick and rich descriptions that are grounded in the participants' experiences (Smith, 2008).

The history of qualitative research is long and vibrant, and its roots can be traced to the disciplines of anthropology, sociology, and philosophy. Qualitative inquiry existed before the start of the 20th century; however, it constituted an unstructured method of field research undertaken by anthropologists and sociologists (Erickson, 2018; Holloway & Wheeler, 2010; Merriam & Tisdell, 2016). In the 1920s and 1930s, more methodical approaches began to emerge through the works of social anthropologists like Malinowski (1922) and Mead (1935), and sociologists at the Chicago School, such as Park and Burgess (1925).

The 1950s and 1960s marked a turning point in the fate of qualitative research as frustration with positivism was mounting and qualitative research practices aspired for improved

rigor (Erickson, 2018). The publication of the seminal book, *The Discovery of Grounded Theory*, by sociologists Glaser and Strauss in 1967 heralded the emergence of present-day qualitative research (Merriam & Tisdell, 2016). The debut of grounded theory and other structured approaches to naturalistic inquiry set in motion a paradigm shift in social and psychological research from the dominant positivist, deductive approach to inquiry to the data-driven, interpretive framework, which continued to unfold through the rest of the 20th century.

The 1970s and 1980s witnessed a burgeoning interest in qualitative research as the number of publications on the subject grew and paradigmatic disputes intensified (Holloway & Wheeler, 2010; Merriam & Tisdell, 2016). Furthermore, researchers in fields outside of anthropology and sociology, such as education, health care, psychology, social work, and administration, began to adapt qualitative approaches to their field. Today, qualitative research has become well-established in applied social research, including counseling (McLeod, 2011; Pope & Mays, 2006). It is far from a monolithic, coordinated approach to inquiry; instead, it draws together diverse research paradigms, traditional and innovative methodological approaches, and a gamut of research methods that both intersect and push back against each other (Brinkmann et al., 2014; Denzin & Lincoln, 2018).

Given the plurality of historical, philosophical, and disciplinary influences on qualitative research, establishing a definition that reflects its complexity and is inclusive of the sundry of research practices that fall under it constitutes a huge challenge (Denzin & Lincoln, 2018; Merriam & Tisdell, 2016). As a result, several scholars have tried to identify the unifying features of qualitative research. Merriam and Tisdell (2016) highlighted four characteristics that are distinctive to qualitative research: (a) an emphasis on meaning and understanding, (b) the primacy of the researcher as an instrument of data collection and analysis, (c) the inductive

nature of the research process, and (d) a richly descriptive research product. Other characteristics that are common to qualitative approaches include: (a) the inquiry is context-dependent; (b) a focus on the emic perspective; (c) the researcher immerses themselves in the natural setting of the participants; (d) the close relationship between the researcher and the researched; (e) the reflexivity of the researcher; and (f) the integrated nature of data collection and data analysis (Creswell & Poth, 2018; Holloway & Wheeler, 2010).

Rationale for a Qualitative Design

A qualitative approach was deemed consistent with the constructivist paradigm, with its focus on how people construct meaning and understanding of their reality based on their social exchanges with their environment (Lincoln et al., 2011). Furthermore, a qualitative study enables the researcher to gain access to the participants' experiences and frames of reference (Denzin & Lincoln, 2018). The purpose of the study was to tease out the subjective meanings held by mental health practitioners, including counselors, who had experience delivering community and society-level interventions to redress the legacy of historical trauma in affected communities and populations. A qualitative design enabled a nuanced understanding of how mental health practitioners construed their involvement in this kind of interventions.

A qualitative design was considered suitable for the present study because its purpose was to investigate how mental health practitioners respond to the phenomenon of historical trauma in specific social contexts. A qualitative design situates the study participants' experiences in their natural settings (Denzin & Lincoln, 2018), thus allowing the researcher to gain insight into the environments in which the individuals address a problem or respond to an issue. Sensitivity to context was critical to the study because historical trauma interventions do not occur in a vacuum.

Furthermore, a qualitative approach was considered relevant to the study because of the limited extant empirical knowledge on the research topic. Qualitative inquiry is particularly appropriate to investigate new areas of inquiry, where little empirical research has been conducted (Pope & Mays, 2006).

Grounded Theory

In the present study, I used constructivist grounded theory as the research methodology. Grounded theory is a "constellation of methods" (Charmaz, 2014, p. 14) that offer systematic, but nonetheless flexible guidelines for collecting, analyzing, synthesizing, and conceptualizing qualitative data to support the construction of theories directly from data. Central to grounded theory methods is that data serve as the foundation to inductively develop conceptual analytic categories through a systematic and iterative process of data collection and analysis (Charmaz, 2014). This sophisticated methodological process generates theories that are 'grounded' in data, hence the name grounded theory.

Charmaz (2010) highlighted the common strategies employed by different grounded theorists. She identified the following practices: (a) concurrent data collection and analysis, (b) a focus on actions and processes instead of themes and structure, (c) constant comparison of data, (d) using data to develop new conceptual directions as opposed to looking for data to corroborate preconceived understandings, (e) developing abstract analytic categories that are grounded in the data, (f) an emphasis on theory construction instead of a conceptual description of the data, (g) theoretical sampling, (h) looking out for variations in the emergent categories, and (i) allowing the development of a category to direct the investigation rather than aiming to cover a specific topic.

Grounded theory methods are concerned with illuminating human behavior and social processes, and the relationship between the two (Charmaz, 2008; Strauss & Corbin, 1998). Grounded theory is useful to expose how individuals negotiate meaning within social settings, and how they position themselves within their social worlds.

Grounded theory is nowadays considered as one of the prominent qualitative methodologies (Birks & Mills, 2012). Researchers in various disciplines and fields of practice such as sociology, anthropology, psychology, education, social work, and nursing have used grounded theory methods to study a vast array of phenomena (Strauss & Corbin, 1998). Similar to other qualitative approaches like ethnography and phenomenology, grounded theory as initially proposed by Glaser and Strauss in the late 1960s has been influenced by competing philosophical orientations and changes in the socio-historical landscape, which led to the splintering of the methodology into disparate approaches.

The Origins and Evolution of Grounded Theory

Sociologists Glaser and Strauss were the earliest proponents of grounded theory methods. Their successful partnership in the early 1960s in a research program that explored the experience of dying in American hospitals gave rise to grounded theory (Glaser & Strauss, 1965, 1967). As Glaser and Strauss examined how terminal patients and medical professionals handled the news of impending death, they developed systematic strategies to analyze the data that led to a new way of doing qualitative research (Charmaz, 2014; Glaser & Strauss, 1967; Payne, 2007).

Glaser and Strauss outlined their methodological strategies in their book, *The Discovery of Grounded Theory* (1967). The proposed methods were aimed at developing theories inductively from the data and could be adopted by social scientists other than sociologists. The book was published at a time when qualitative research was receding in the shadows and

quantitative methods rooted in positivism were gaining prominence, threatening sociology's long tradition of ethnographic fieldwork, case studies, and interviews (Charmaz, 2014). Glaser and Strauss (1967) sought to promote the legitimacy and credibility of qualitative research by making a case for its analytical and explanatory power. The authors strongly critiqued the prevailing research norms at the time, particularly the 'logico-deductive' approach espoused by positivist researchers. They argued that research designed to test hypotheses deduced from existing theory rarely led to theoretical innovations. Glaser and Strass' work set in motion a revolution in qualitative research that eventually inspired researchers in various disciplines to pursue qualitative inquiry (Charmaz, 2014). Their joint publication is regarded as the first generation or the classical formulation of grounded theory (Birks & Mills, 2011; Payne, 2007).

Glaser and Strauss (1967) did not discuss the epistemological underpinnings of their strategies and methods, which became a major criticism of their work (Birks & Mills, 2011). Nonetheless, their original formulation of grounded theory reflects the divergent epistemological positions subscribed by the respective schools from where it originated (Charmaz, 2014). Grounded theory as proposed by Glaser and Strauss (1967) has its epistemological roots in positivism, pragmatism, and symbolic interactionism, and it thus bridges positivist and interpretative epistemological traditions (Charmaz, 2014). Its emphasis on using systematic techniques to study an external world that exists independently of the researcher is in keeping with positivism and reflects Glaser's quantitative training at Columbia University with its allegiance to the positivist tradition. On the other hand, the concepts of human agency, social and subjective meanings, process, and action were derived from pragmatism and symbolic interactionism and can be traced to Strauss' background at the University of Chicago with its legacy in pragmatism.

In time, Glaser and Strauss began to disagree on what constitutes the "correct" procedure to conduct grounded theory research (Payne, 2007). According to Stern (1994), although the differences between the two researchers had always existed, their divergent views came into the open when Strauss issued detailed guidelines on how to conduct grounded theory research (Strauss, 1987; Strauss & Corbin, 1990). Strauss and Corbin (1990), in their first edition of *Basics of Qualitative Research*, tried to address some of the ambiguities in the procedures outlined in the original text, thereby providing more guidance to new researchers. However, their text departed in several ways from Glaser and Strauss' (1967) initial statement. Thereafter, Glaser and Strauss took forward grounded theory in different directions, which gave rise to the establishment of two schools of grounded theory: the Glaserian and the Straussian approaches to grounded theory (Charmaz, 2014; Garson, 2016). Much has been written about the rift between the two researchers; some of these writings expressed polarized opinions and positions, whereas other authors tried to differentiate between the two approaches (e.g. Evans, 2013; Heath & Cowley, 2004; Howard-Payne, 2016; Kendall, 1999; Robrecht, 1995). In the following subsection, I highlight some of the key features and discrepancies between these two schools of grounded theory.

The Glaserian and Straussian Approaches to Grounded Theory. Glaser remained faithful to classical grounded theory as attested by his later publications (Glaser, 1978, 1992, 1998). Induction is the cornerstone of the Glaserian approach to grounded theory (Glaser, 1992). The Glaserian school emphasizes the notions of discovery and allowing categories to emerge from the data. Glaserian grounded theory is both meticulous and parsimonious, and advocates for simple, systematic procedures that facilitate the emergence of theory (Grbich, 2013; Payne, 2007). It relies on substantive coding, constant comparison, and theoretical sampling (Glaser,

1992). The purpose of these techniques is to identify underlying patterns in the data that give rise to theoretical abstraction.

Glaser (2005) resisted aligning grounded theory to a specific research paradigm, stating that grounded theory is a stand-alone research methodology. He maintained that grounded theory methodology should remain open and adopt a philosophical lens that is compatible with the emergent theoretical categories in a particular research study. Glaser's abstruseness on this subject was met with considerable criticism (e.g. Bryant, 2009). However, some consensus exists that the Glaserian approach operates from a post-positivist paradigm (Hallberg, 2006; Howard-Payne, 2016; Urquhart, 2002). This theoretical orientation has its ontological roots in critical realism. Critical realism purports that there is a single external reality but it can never be accurately grasped (Guba & Lincoln, 2005). The epistemological stance adopted by the Glaserian school is that findings are discovered from the data through a purely inductive process by a neutral researcher who is removed from the process (Howard-Payne, 2016).

Strauss and Corbin (1990, 1998), in their reformulation of grounded theory, proposed additional analytic coding techniques and paid less attention to the comparative methods and the emergent theoretical categories that characterized the classical version. The Straussian approach provides more structured coding procedures than its classical counterpart (Evans, 2013). It offers guidelines on how to undertake open coding that involves analytic questioning of the data (Strauss & Corbin, 1990). The constant critiquing of data and the comparing of data with other data help to 'break up' the text. Additionally, Strauss and Corbin (1990) proposed three stages of coding, starting with open coding, followed by axial coding, and finally selective coding. They also developed a coding paradigm to direct the process of establishing relationships between categories during axial coding.

Strauss and Corbin's prescriptive approach garnered substantial criticism, with some researchers claiming that their techniques instilled rigidity in data analysis (Charmaz, 2000; Keddy et al., 1996; Melia, 1996), and others arguing that theory emergence is problematic (Glaser, 1992; Robrecht, 1995). Glaser (1992) strongly rebutted the use of axial coding in data analysis. He claimed that axial coding was antithetical to the central tenets of grounded theory, and that this strategy could yield only a thorough conceptual description of the data but not grounded theory. Strauss and Corbin, in the second and third editions of their text (Strauss & Corbin, 1998; Corbin & Strauss, 2008), tried to promote more flexibility around the use of their proposed procedures.

Another major shift from the original work is the greater prominence afforded to the processes of deduction and verification during data analysis (Heath & Cowley, 2004). This emphasis on deduction and verification signaled a departure from the purely inductive logic of classical grounded theory (Charmaz, 2014). Although induction remains an important aspect in the Straussian approach, Strauss and Corbin (1994) maintained that induction should not be overplayed. They in turn suggested an analytic process in which the researcher makes deductions from the data followed by verification with the data, which was later termed validation (Strauss & Corbin, 1990, 1998). Their explanation of grounded theory analysis rests on a dynamic interplay among induction, deduction, and validation, echoing Peirce's (1878/1958) concept of abductive reasoning (Bryant & Charmaz, 2007; Charmaz, 2014; Reichertz, 2007).

Strauss and Corbin's adaptation of grounded theory adopts a more interpretative stance (Charmaz, 2014). The Straussian approach is steeped in the related philosophical traditions of pragmatism and symbolic interactionism, and accordingly it operates from a post-positivist

framework and is based on a critical realist ontology (Strauss & Corbin, 1998). In terms of epistemological orientation, the purpose of Straussian grounded theory research is to move closer toward an accurate representation of reality, and the findings constitute the researcher's interpretation of different perspectives. The researcher is personally engaged in the research process in an effort to better understand the participant's world, which is exemplified by the approach's emphasis on deduction and validation, fastidious interrogation of the data, and a more prescriptive coding structure in data analysis (Evans, 2013; Howard-Payne, 2016).

Developments in the Postmodern Era. In the 1990s, postmodern and narrative thinkers contested the epistemological roots of grounded theory methods, in particular, its modernist overtones concerning truth, universality, human nature, science, and worldviews (Charmaz, 1990; Conrad, 1990; Ellis, 1995). Notions about an objective external reality, a detached, neutral observer, and constricted empiricism clashed with postmodern thought and its presuppositions of a social reality that is multiple, fluid, and constructed (Charmaz, 2014). From a postmodernist perspective, the researchers with their positions, values, and beliefs are constructing reality with the participants. Postmodern advocates also opposed the authoritative stance of the researchers.

During this time, several scholars contributed to the development of grounded theory by framing it within their own epistemological positions, drawing it further away from positivism (Charmaz, 2014). This led to other variations of grounded theory. Such examples include constructivist grounded theory championed by Charmaz (1990, 2000, 2006, 2014), feminist grounded theory (Wuest, 1995), Clarke's (2003) postmodern adaptation, and Rennie's (2000) methodological hermeneutics iteration. Constructivist grounded theory, the chosen research methodology for the present study, is discussed next.

Constructivist Grounded Theory

Constructivist grounded theory is one of the more recent genres of grounded theory that gained increasing attention toward the end of the last century (Birks & Mills, 2011; Charmaz, 2014, Grbich, 2013). Charmaz, a former student of Glaser and Strauss, motivated by a constructivist philosophy, broke from both classical and Straussian grounded theory and forged a new constructivist adaptation (Birks & Mills, 2011). Constructivist grounded theory approaches reality from a relativistic viewpoint (Charmaz, 2014). A key assumption of the constructivist approach is that truth and reality are contingent on the individuals' perceptions and experiences, therefore acknowledging the presence of multiple, diverse social realities. Meaning and research are conceptualized as being co-constructed through the involvement and interaction of the researchers with the researched. It rejects the claims made by critical realists that a reality exists independently of observers or the idea that research is a discovery-oriented endeavor undertaken by the researcher (Charmaz, 2000).

Nevertheless, constructivist grounded theory embraces several elements of the original work by Glaser and Strauss (1967), including its inductive, comparative, emergent, and open-ended style (Charmaz, 2014). It also retains the iterative dialectic emphasized by the Straussian formulation, as well as the concepts of action and meaning that can be traced back to pragmatism and symbolic interactionism. Charmaz (2000), however, contested the rigid and prescriptive coding structure advanced by Strauss and Corbin (1990, 1998), arguing that it stifles the researcher's creativity and obscures the participants' experiences. By contrast, constructivist grounded theory offers accessible and flexible guidelines to conduct grounded theory research, and relies on two types of coding: open and focused (Charmaz, 2014). Similar to Glaser (1992),

Charmaz (2008) advocated for methodological flexibility and insisted that the researcher must be able to tolerate ambiguity as part of the research process.

Hallberg (2006) depicted the constructivist turn in grounded theory as part of an evolutionary progression that started with the development of classical grounded theory in the 1960s, continued in the 1990s with the Straussian adaptation, and led to the constructivist formulation in the 2000s. Charmaz (2000, 2014) argued that the constructivist approach acts as a bridge between positivism and postmodernism.

The distinctions in the epistemological orientations of classical/Glaserian, Straussian, and constructivist grounded theory have important implications for the role of the researcher in the investigation. Constructivist grounded theorists assume a reflexive stance on the researcher's involvement in the research process (Charmaz, 2014). They take into account their position, values, and beliefs, and they situate themselves in their participants' realities. Bryant (2003), another proponent of constructivist grounded theory, pointed out that the constructivist approach directly addresses the challenges of researcher bias. Glaser (2002) rejected the constructivist perspective; he perceived the researcher as taking a more neutral and passive role in receiving the data. Furthermore, Glaser cautioned researchers against overreliance on reflexivity because it can divert the researcher's attention from the data.

A central precept of constructivist grounded theory, based on a relativistic epistemology, is to give voice to participants and allow their multiple voices to be represented in the final product (Breckenridge et al., 2012; Kenny & Fourie, 2015). Owing to its commitment to privilege participants' perspectives, constructivist grounded theory does not necessarily culminate into a predicative theory that captures a latent pattern of behavior in the data as in the case of classical grounded theory, or the identification of a core category that accounts for the

relationships in the data as purported by the Straussian school (Hallberg, 2006). Constructivist data analysis instead yields the researchers' interpretative understanding of the studied social phenomenon, which is presented as a conceptual description in the form of a story. The theoretical abstraction is incorporated into the conceptual narrative (Charmaz, 2014; Hallberg, 2006). Glaser (2012) strongly objected to the constructivist emphasis on the researcher's interpretative representation of the participants' voices, stating that this focus undermines the primary goal of grounded theory, which is generating overarching theoretical explanations of studied life. He further argued that the constructivist adaptation cannot be considered as grounded theory and would be more accurately classified as qualitative data analysis.

Rationale for Using Constructivist Grounded Theory

Grounded theory is uniquely suitable to investigate social processes and the interaction between individuals and their social context because of its roots in pragmatism and symbolic interactionism (Chamberlain-Salaun et al., 2013). Elements of pragmatism and symbolic interactionism are also alive in constructivist grounded theory (Charmaz, 2014). Charmaz claimed that process and action are central to constructivist grounded theory.

A constructivist grounded theory approach helped illuminate how the meanings that mental health practitioners ascribed to historical trauma, collective interventions, and their unique professional role shape how they respond to historical trauma at the community and society levels. It also helped uncover how mental health counselors negotiate meaning around their professional identity when delivering collective historical trauma interventions. Constructivist grounded theory was therefore considered an appropriate methodological approach to address the research questions guiding the study. Additionally, the research

questions that guided the investigation leaned towards action and process ("how" questions) rather than states and conditions (Strauss & Corbin, 1998).

Because the focus of the study was on social processes, other qualitative methodologies, including phenomenology, narrative, and ethnography were not considered appropriate. The purpose of the study was neither to explore the lived experiences of mental health practitioners who worked with populations affected by historical trauma, nor to expose how mental health practitioners make sense of their personal experiences of delivering collective interventions in communities affected by historical trauma through their storytelling. Furthermore, the purpose of the study was not congruent with the principal goal of ethnographic research, which is to cast light on the inner workings of a designated culture, such as its operations, customs, rituals, attitudes, and belief systems (Grbich, 2003).

The decision to use constructivist grounded theory instead of the classical and Straussian versions was predicated on: (a) its suitability to the type of data gathered, (b) its fitness to the research paradigm framing the study, (c) logistics of the literature review process, and (d) its congruence with the researcher's personal beliefs on reality, knowledge, and research. As stated earlier, constructivist grounded theory upholds a sense of obligation toward capturing multiple participant voices and allowing manifold truths to be recognized (Breckenridge et al., 2012; Kenny & Fourie, 2015). The commitment to honor multiple realities over the search for a singular explanatory pattern or a core category in the data was consistent with the plurality of perspectives that I intended to capture through interviewing mental health practitioners who delivered collective historical trauma interventions with different populations and in diverse sociocultural contexts.

Additionally, constructivist grounded theory was considered to be the best fit for the constructivist orientation of the study. Constructivist grounded theory and a constructivist research paradigm hold similar views concerning the researcher's involvement in the research process. According to the constructivist theoretical framework, the inquirer is a "passionate participant" (Guba & Lincoln, 2005, p. 196) who shapes meanings and knowledge together with the research participants. Constructivist grounded theory likewise acknowledges that researchers are social actors whose histories, experiences, knowledge, ideas, and assumptions color their interactions with the study participants and their understanding of the social processes under investigation (Charmaz, 2014).

Furthermore, constructivist grounded theory was considered a more appropriate match for the study because of its stance on the use of literature. The classical/Glaserian approach insists on delaying the literature review process, leaving more focused reading until the end of the research process to allow for the emergent theory to develop independently (Glaser, 1978, 1998, 2011; Hickey, 1997). Echoing this sentiment, Christiansen (2011) instructed researchers who cannot delay a pre-study literature review to consider choosing a different research methodology. On the other hand, Strauss and Corbin (1998) recommended doing a partial literature review prior to conducting field research to stimulate theoretical sensitivity, and to continue consulting the literature through the different stages of the investigation. Constructivist grounded theory takes a similar position as the Straussian approach in terms of the timing and approach to the review of the literature (Charmaz, 2014). This position is in keeping with the constructivist research paradigm, which acknowledges that research does not happen in a vacuum (Kenny & Fourie, 2015). Charmaz's strategy (2014) to confer with the literature prior to carrying out a study aligns better with the requirements of a doctoral dissertation. However, it

was not possible to follow her other suggestion to defer the actual writing of the literature review chapter until after data analysis.

Lastly, constructivist grounded theory was preferred over other versions of grounded theory because it is consistent with my beliefs on the nature of reality, knowledge, and research. A similar argument was advanced by several grounded theorists, who argued that the choice of approach has little to do with the superiority of the method but more with its fitness to the data and the researcher (Bryant, 2009; Evans, 2013; Heath & Cowley, 2004; Walker & Myrick, 2006). These researcher-related considerations are discussed in more detail in the next section.

Role of the Researcher

The decision to use grounded theory as the research methodology for the present study was only the starting point of my research journey. As I discussed in the previous section, arriving at an informed decision about which school of grounded theory to adopt for the study was influenced by several factors, including my philosophical positioning as a researcher and as a counseling professional. Walker and Myrick (2006) argued that the choice of methodology "is more about the researcher and less about the method" (p. 558), a view espoused by other scholars (Bryant, 2009; Fendt & Sacks, 2008; Fernandez, 2012). First, I was drawn to constructivist grounded theory because of its flexibility and intuitive creativity as a research methodology.

Additionally, constructivist grounded theory (Charmaz, 2014) resonated with me because of its ontological and epistemological roots. I believe that truth is subjective, and that social reality is co-constructed by individuals as they interact with and ascribe meaning to the world around them. My worldview is based on my day-to-day and clinical observations of people who at face value seem to be going through similar experiences, but whose interpretations of events are completely different due to their personal histories, beliefs, values, and cultural factors. I

therefore reject the notion that the goal of empirical research is to discern some latent meaning underlying an objective reality as proposed by classical grounded theory.

Constructivist grounded theory assumes the existence of multiple social realities and attempts to capture the plurality of participants' meanings of a phenomenon (Charmaz, 2014). As a counseling professional who leans toward a feminist, relational-cultural therapeutic orientation, I find that the privileging of multiple perspectives aligns better with how I conceptualize clients and people in general, their challenges, and their social realities. Feminist therapists dispute claims about "objective truth" that have been exploited to preserve patriarchy and other systems of oppression, and instead acknowledge different ways of knowing (Corey & Herlihy, 2016). In feminist therapy, diverse client realities and voices are honored both within and outside of therapy. Similarly, constructivist grounded theory privileges participants' voices over identifying a main concern or a core category in the data as prescribed by earlier formulations of grounded theory methodology (Breckenridge et al., 2012; Kenny & Fourie, 2015). Constructivist grounded theory strives to construct a theoretical product that reconciles the different participants' voices, perspectives, and experiences.

Furthermore, grounded theorists who align themselves with the constructivist perspective advocate a mutual relationship between the researcher and the researched as co-creators of meaning and knowledge (Charmaz, 2014). Their position counters the distant relationship endorsed by classical grounded theory that allows researchers to "assume the role of authoritative analysts who bring an objective view to their research" (Charmaz, 2014, p. 237). Constructivist grounded theory draws attention to issues of power inherent in the research process. Constructivist grounded theorists try to shift the power back to the study participants, who are viewed as experts. This perspective is more congruent with the principles of feminist

therapy, which invite an open dialogue about power as part of the therapeutic process and the sharing of power with clients through cultivating egalitarian counseling relationships (Corey & Herlihy, 2016).

Finally, constructivist grounded theory redefines the role of the researcher by challenging the positivist assumptions of a "neutral" investigator. Researchers are not objective reporters discovering the hidden patterns underlying the empirical world; rather, they are co-creators of meaning, and therefore they have an impact on the research process (Mills et al., 2006). The research findings are the product of a collaborative, dialectical process that is influenced by the researcher's knowledge and experiences. As a researcher, I do not see myself as an impartial rapporteur. I acknowledge that I brought my beliefs, preconceptions, and biases to the study, which could not be entirely separated from the research process. I am therefore making explicit my frame of reference and preconceptions in this section, along with an explanation of how they informed the inquiry (Charmaz, 2014).

Researcher's Frame of Reference and Preconceptions

My initial interest in the topic of historical trauma grew out of my research and outreach initiatives with asylum seekers and immigrants in Malta before I enrolled in the doctoral program in counselor education and supervision at the University of New Orleans. Many of the migrants' personal accounts revealed trauma resulting from witnessing political violence and persecution, and being forced to leave their home country. Their stories sensitized me to the far-reaching grip of trauma that seemed to prevail long after the immigrants had settled in a new country, and in some cases left its footprint on the lives of their children although they had not witnessed firsthand the tragic events that banished their parents from their country of origin. My interactions with the migrant families prompted me to question how mental health professionals

can reach out to this population in meaningful and culturally-sensitive ways. I also started to realize that traditional one-to-one counseling interventions may not work with some of the migrants who hailed from more collectivistic cultures. Consequently, I became more convinced that collective interventions would be more appropriate and effective in these situations. Furthermore, collective interventions offer the advantage of targeting larger numbers of people than individual therapeutic approaches.

My insights from these exchanges with the immigrants were crystallized some years later while I was facilitating a workshop in New Orleans with a mixed group of Catholic and Protestant youth from Northern Ireland. None of these young people, whose ages varied between 12 and 18, had experienced directly the "Troubles," but they undeniably carried the scars of their family and community trauma. As the youth opened up about their experiences in their country, frustrations and resentments about the present-day sociopolitical landscape in Northern Ireland began to surface. Some of their remarks alluded to structural and cultural forms of violence that seemed to perpetuate the collective trauma into the future. I will never forget the metaphor used by one of the youth who likened the hidden tensions in Northern Ireland to gasoline on the ground that just needed a small spark to set off an explosion. The participant's remark spoke to the interlocking cycles of violence and trauma.

On a personal level, I was born and raised in Malta, a small island in the southern perimeter of Europe. Malta's culture embodies the diverse influences of its neighboring Mediterranean countries, as well as its numerous colonizers who ruled the inhabitants for several centuries until it gained independence in 1964. Although I have no personal experience of mass political violence and historical trauma, I am well acquainted with the colonial mentality that still

prevails in contemporary Maltese society, and how it continues shaping the psyche and way of life of present-day generations.

All these experiences shaped my personal and professional worldview in a profound way, and inspired my interest to study collective historical trauma interventions for my dissertation study. As I delved into the relevant literature, I learned that although the concept of historical trauma dates back several decades, little empirical research exists on community- and society-level interventions to address this phenomenon. In addition, the literature contains little mention of counselors in these types of interventions.

As a counseling professional who aligns with a feminist therapeutic orientation, I strongly concur with the statement that the personal is political, which means that an individual's problems and distress have their roots in a sociopolitical context. In the case of historical trauma, the legacy of trauma is a collective response to a psychological and social violation caused by past and present-day experiences of politically motivated violence, subjugation, and oppression. Because historical trauma stems from sociopolitical dynamics that fall outside the scope of individual personal power, I firmly believe that it cannot be solely addressed through interventions that target individual healing and recovery. Redressing the grievances of historical trauma warrants the use of collective interventions that strive for social and political transformations and pave the way for greater equity, social justice, and sustainable peace in communities and societies.

Participants

The next step in a qualitative study is to identify suitable research participants who can shed light on the phenomenon under investigation and assist the researcher to answer the research question(s) (Merriam & Tisdell, 2016). In the present study, I explored the perspectives

of various mental health practitioners who had worked with populations affected by historical trauma and delivered psychosocial interventions that address historical trauma at the community and society levels.

Prior to data collection, my plan was to divide the sample evenly between counselors and other mental health practitioners in order to ensure a suitable representation of the former. Achieving such a balance in the study sample would have been useful to answer the second research question, "What functions *do* mental health counselors assume in the delivery of collective historical trauma interventions?" No mental health professional could answer better this question other than counselors themselves. Because not enough counselors were recruited in the study and their perspective could not be represented as distinctively as originally planned, I decided to rephrase the second research question to "What functions *can* mental health counselors assume in the delivery of collective historical trauma interventions?" The minor revision to the second research question was made to reflect the nature of the collected data and the professional identity of the respondents.

Sampling Strategy

The sampling strategy consisted of two stages: initial sampling followed by theoretical sampling. Initial sampling enables the researcher to gain access to the data, whereas theoretical sampling provides direction to the research process (Charmaz, 2014). Initial sampling involves establishing the sampling criteria to identify potential participants who can best contribute to the understanding of the phenomenon under study and developing a plan to reach out and recruit those participants. In the study, initial sampling was used to identify potential participants who met the sampling criteria presented in the next section and to start preliminary data gathering. I switched to theoretical sampling when the first tentative analytic categories start emerging,

which happened right after my ninth interview (Charmaz, 2014). By then, I had already discerned a number of tentative analytic categories. Most of these tentative categories were honed and refined as the analysis progressed, and eventually made it to the final set of conceptual categories.

Theoretical sampling is the recursive "seeking and collecting [of] pertinent data to elaborate and refine categories in your emerging theory" (Charmaz, 2014, p. 192). Originally proposed by Glaser and Strauss (1967), theoretical sampling is both unique and integral to grounded theory, and is not to be confused with traditional qualitative sampling approaches. In theoretical sampling, the researcher engages in reciprocal periods of collecting and analyzing data, and based on the emerging theoretical constructs, decides on the subsequent data to be collected in order to develop the nascent theory (Charmaz, 2014). Theoretical sampling is thus an evolving process that is undertaken in the service of the emerging theory, hence the name theoretical sampling (Merriam & Tisdell, 2016). Charmaz (2014) described theoretical sampling as "strategic, specific, and systematic" (p.199), and cautioned researchers against using theoretical sampling prematurely in the investigation. The author suggested using theoretical sampling only when the researcher discerns preliminary analytical categories, so as to avoid common pitfalls such as early closure of theoretical categories or unclear categories. In the present study, theoretical sampling informed the iterative process of moving back and forth between data collection and analysis. Theoretical sampling was used to focus and streamline data-gathering and analysis for the purpose of developing and refining emerging theoretical categories and reaching theoretical saturation. For instance, as I moved forward in the analysis, I was interested to identify participants who had worked with different or more than one group

affected by historical trauma to understand if the analytic patterns that I was noticing were true across different target populations.

Sampling Criteria

Participants were eligible to join the study if they had (a) direct experience working with populations that are affected by historical trauma, and (b) practical experience in delivering collective mental health interventions that address historical trauma at the community and society levels. Prior to data collection, I had established another inclusion criterion; participants had to be recognized as mental health professionals in their country of residence. I dropped this parameter early on in the study when it became clear that the requirement was putting a limit on interviewing potential participants who had plenty of experience delivering mental health interventions to address historical trauma at the community and society levels, but who did not identify as mainstream mental health professionals. The exclusion criteria were (a) lack of fluency in the English language, and (b) lack of access to the technology necessary to participate in an online interview.

Sample Size

In qualitative research, there is no standard formula to determine the minimum number of cases needed to generate trustworthy research findings. Decisions about sample size are arbitrarily made by the investigators and depend on a number of considerations, such as the nature of the research questions, the type of data being gathered, the course of the data analysis, and the available resources supporting the study (Merriam & Tisdell, 2016). Lincoln and Guba (1985) suggested that sampling of new cases should continue until saturation is reached.

The concept of theoretical saturation was introduced by Glaser and Strauss (1967) to signal the point when theoretical sampling should cease in a grounded theory study. Charmaz

(2014) defined theoretical saturation as the stage when no new properties pertaining to the theoretical categories are identified through successive rounds of data collection and analysis and all categories are conceptually dense and robust. In other words, saturation is achieved when further data collection generates no new information or theoretical insights into the established analytical categories. Theoretical saturation is the ultimate guiding principle for sample size in grounded theory (Charmaz, 2014; Glaser, 1992, 1998; Strauss & Corbin, 1998). Bowen (2008) claimed that sample size should matter only as it relates to whether or not theoretical saturation has been reached.

The sample included 12 mental health practitioners. Theoretical saturation was reached after interviewing 11 participants, seven of whom had already participated in two interviews by then. The analysis thus far had revealed six conceptual categories that were clearly fleshed out. At the time, I had already scheduled an initial interview with the twelfth participant. I decided to proceed with this interview and to continue scheduling follow-up interviews with the rest of the participants. This last set of interviews were carried out with the intent to continue corroborating the established conceptual categories and the relationship between them.

When designing a grounded theory study, it is difficult for researchers to anticipate the required sample size to reach theoretical saturation prior to obtaining and analyzing the actual data (Bryman, 2012). This dilemma has practical implications when trying to submit a proposal to an institutional oversight board or a funding agency. To mitigate this challenge, some authors offered guidance on how to determine a tentative sample size in grounded theory and other types of qualitative studies. Thomson (2011) conducted a content analysis of 100 articles that used grounded theory as a methodology and interviews as a data collection method, and found the average sample size to be 25, with saturation typically occurring between 10 to 30 interviews.

The author recommended projecting for 30 interviews to ensure complete saturation. Furthermore, Thomson argued that theoretical saturation is influenced by a number of elements, including the scope of the research question(s), the sensitivity of the research topic, and the researchers' competence in conducting interviews and their knowledge of the research area.

Morse (2000) highlighted similar factors that researchers need to consider when estimating the number of participants, including the scope of the study, the nature of the topic, the quality of the data, the type of study design, and the use of shadow data. The author recommended a sample size of 20 to 30 participants for grounded theory studies. Morse (2000) suggested that there is "an inverse relationship between the amount of useable data obtained from each participant and the number of participants" (p. 4). The extent of useable data is in turn dependent on the quality of the data and the number of interviews per participant. The quality of the data is influenced by the choice of participants (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Choosing participants who are well versed in the phenomenon under investigation can reduce the sample size. Similar to Morse (2000), Lee et al. (2002) maintained that studies involving multiple interviews with the same participants or mixed data collection methods require a smaller sample.

Charmaz (2014) explained that there is great contention among grounded theorists around how many interviews should be conducted in grounded theory studies. Some scholars defended very small sample sizes whereas others advocated for larger interview samples (e.g. Glaser, 1998). Charmaz (2014) stated that there is no straightforward answer to this question and that a large sample size does not necessarily guarantee more significant findings. The author argued that sample size is contingent on the purpose of the study and the aspired level of conceptual analysis. Saturation can be achieved earlier in studies that have a clearly focused purpose and a

modest scope. Limited conceptual analysis of the data can also result in premature saturation. Charmaz (2014) also claimed that factors such as heterogeneity among participants, sensitivity of the research topic, controversial findings, using interviews as the only means of gathering data, and the use of unstructured interviewing call for an increased number of participants.

Based on the literature discussed above, it can be argued that a sample size of 12 participants was adequate to saturate the emergent categories based on my decision to conduct more than one interview with each participant and to use semi-structured interviews. Prior to reaching theoretical saturation, I was open to increasing the sample size as necessary to ensure that complete saturation of the theoretical categories was attained. Further details about the procedures and methods for data gathering are provided in the next section.

Participant Recruitment

First, permission for human subjects' research was sought from the Institutional Review Board at the University of New Orleans. A copy of the Institutional Review Board exemption letter is included in Appendix A. A list of potential contributors was compiled based on a thorough literature and internet search. Upon receiving approval from the Institutional Review Board, I embarked on initial sampling by contacting potential participants via email and inviting them to participate in the study. A copy of the invitation is included in Appendix B.

The invitation included an informed consent letter that provided participants with a brief description of the study, the eligibility criteria to participate in the study, the nature of the participants' involvement in the research project, potential benefits and risks of partaking in the study, and the participants' rights to confidentiality and to withdraw their participation from the study at any point. A copy of the informed consent letter is included in Appendix C. Interested mental health practitioners who wished to take part in the study were asked to fill out and sign an

electronic informed consent. They were also encouraged to reach out to me if they had questions or queries. As part of the informed consent, participants were asked to confirm their preferred email account and choose their preferred videoconferencing software to participate in an online interview. Next, I contacted the confirmed participants via email to schedule the initial interview. Participants were asked to fill out a brief demographic questionnaire prior to first interview. A copy of the demographic questionnaire is included in Appendix D. Further participant recruitment followed the logic of theoretical sampling. By the end of the study, a total of 57 potential participants had been invited to take part in the study.

Data Collection Methods

In the study, I used intensive interviews to gather relevant data to answer the research questions. Research participants were asked to participate in two one-on-one interviews: an initial interview and a follow-up interview. The purposes of the follow-up interview were to (a) clarify statements and any discrepancies from the first interview, (b) check out any promising leads to further my understanding of salient social processes in the studied world, and (c) pursue emerging theoretical ideas and directions in support of theory construction. I conducted a total of 22 interviews with 12 participants. Ten of the participants took part in both the initial and the follow-up interview; the rest took part in one interview.

The interviews were conducted online using videoconferencing technology to facilitate the recruitment of a diverse sample of mental health practitioners from across different geographical regions around the world. Each interview lasted between 50 minutes and one and a half hours. All interviews were audio-recorded and transcribed for data analysis purposes.

Intensive Interviewing

The overarching goal of grounded theory research is to generate a nuanced substantive theory that is anchored in rich data. Gathering rich data involves engaging with the studied phenomenon, which can be accomplished through various methods including ethnographic observations, reviewing relevant documents, focus group interviews, and one-on-one interviews (Charmaz, 2014). Deciding on which data-gathering method(s) to use depends on the research topic and data access.

Interviews are the most prevalent data-gathering method in grounded theory research (Charmaz, 2014). Intensive or in-depth interviewing is an effective instrument to gain insight into a phenomenon from the vantage point of research participants who have experience that is relevant to the research topic. This type of interviewing allows for an in-depth and open-ended examination of the participants' experiences and their social contexts. In grounded theory research, intensive interviewing serves not only as a tool to learn about a phenomenon, but it is also a means to advance theory development as the researcher moves back and forth between data collection and analysis (Charmaz, 2014). Pursuing theoretical insights and directions by focusing the line of questioning blurs the line between data collection and analysis in grounded theory research. This aspect creates a distinction between the use of intensive interviewing in grounded theory studies and its application in other types of qualitative inquiry.

Charmaz (2004) emphasized that the choice of data collection method(s) should flow from the research question(s). Intensive interviewing was deemed suitable for the present study because it helped elicit and explore the experiences, meanings, perspectives, and actions of mental health practitioners who had first-hand experience delivering collective interventions with populations affected by historical trauma.

Additionally, intensive interviewing is compatible with interpretative inquiry, such as constructivist grounded theory research, because it facilitates the researcher's understanding of the interview participants' constructions of their experiences. It provides a space for the researcher and the study participants to negotiate and co-construct meaning of the studied phenomenon. Also, both intensive interviewing and grounded theory methods "are open-ended yet directed, shaped yet emergent, and paced yet unrestricted" (Charmaz, 2014, p. 85). The two methods are complementary because they both afford a combination of flexibility and control to the researcher that enhances analytic acuity.

A constructivist approach to intensive interviewing. A constructivist approach to intensive interviewing favors a more egalitarian exchange between the researchers and interview participants which contrasts with the notion of a "detached" interviewer espoused by classical grounded theorists (Charmaz, 2014). The shared human connection creates a space not only for researchers to develop fresh analytic insights about the studied life, but for participants to reconstruct new understandings of their own experiences. The elements of collaboration and mutuality also allow constructivist interviewers to cede their power and control of the interview to the participants.

Constructivist grounded theorists acknowledge that interviews do not hold up a mirror to reality, but also argue that interviews are more than a performance to suit the research situation (Charmaz, 2014). Interviews are an emergent construction by the interviewer and the interviewed, a "site of exploration, emergent understandings, legitimation of identity, and validation of experience" (Charmaz, 2014, p. 91). Because constructivist grounded theorists view the interviewing process as a mutual construction, they pay close attention to the use of language and how data are co-constructed during interviews (Charmaz, 2014). They thus invite

interview participants to define and explicate the terms and statements they use. They also reflect on how their involvement in the interaction, such as how they formulate questions, shapes the data.

Interview guide. The interviews followed a semi-structured format, which is consistent with intensive interviews. I made use of an interview guide to help me steer the interview conversations. A copy of the interview schedule is included in Appendix E.

A carefully constructed interview guide helps researchers be prepared for the interview conversation, such as how to soften sensitive questions, remain present with the participants during the interview, and avoid getting derailed when research participants wander off from the subject (Charmaz, 2014). Developing a guide also helps uncover unexamined preconceptions that researchers may inadvertently foist on the research participants through their line of questioning.

The interview guide for the study consisted of a set of open-ended questions that ranged from broad to more focused questions. Open-ended questions invite interview participants to frame their responses based on their experiences and understandings rather than on the researcher's preconceptions and values (Charmaz, 2014). They elicit richer data because they encourage research participants to reflect anew and more deeply on a phenomenon. The questions in the guide addressed the research objectives and covered key areas related to the research topic. I used the interview guide as a flexible tool to focus the data-gathering process while simultaneously keeping the interview discussions organic to pursue new directions when significant unexpected discoveries were made (Charmaz, 2014). The interview guide was revised and fine-tuned to mirror the evolving nature of data-gathering in grounded theory research that is shaped by theoretical sampling.

Online Interviews

All the interviews for the study were conducted online using videoconferencing technologies that permit real-time, synchronous communication, such as Skype and Zoom. Online interviewing were deemed suitable because it extended the reach of the study beyond the local geographical area. It also increased the diversity of the research participants by enabling data gathering from mental health practitioners from different cultural backgrounds, who would have been otherwise difficult to access because of geographical distribution and concomitant time and financial constraints.

Internet-mediated research involves the collection of primary data via the Internet (Hewson, 2008). The rapid technological advancements in the past few decades have inspired the use of online interviewing in qualitative inquiry (Hooley, Wellens, & Marriott, 2012). Online interviews follow the same steps as conventional qualitative interviews, but they add a technological layer to the interviewing process (Salmons, 2015). In online interviews, the interaction between the researchers and study participants is mediated through information and communications technology, which changes the nature of the communication in both explicit and subtle ways.

Web conferencing technologies allow for a synchronous, verbal and visual interface (Salmons, 2015). Synchronicity is characterized by high-quality, real-time communication that enables interlocutors to reach convergence of understanding (Dennis, Fuller, & Valacich, 2008). Consequently, the interaction in videoconferencing resembles in many respects the natural back-and-forth exchange in face-to-face interviews. The researchers can pick up on both verbal and nonverbal cues, including pacing of speech, silence, intonation, pitch, facial expressions, and gestures (Salmons, 2015). The conversational nature of videoconferencing pairs well with a

semi-structured interviewing style. Furthermore, online interviewing is an emergent method that can generate rich data (Salmons, 2015), in the same way as conventional intensive interviewing. Because online interviews using videoconferencing technologies bear many similarities with traditional intensive interviews, they aligned well with the purpose and design of the study.

Research participants could choose to have the online interviews using one of two videoconferencing platforms, either Skype or Zoom. They were asked to select their preferred videoconferencing platform when providing their informed consent to participate in the study. The choice of these two videoconferencing technologies was based on: (a) both technologies are widely used and readily available to use or install from the Internet, which increased the likelihood that the participants were familiar with the technologies; (b) both technologies offer free access, which means that the participants would incur no cost to participate in the interview; and (c) my familiarity with the technologies. Additionally, both technologies offer similar features and therefore can be used interchangeably, meaning that the difference between the two will not influence the quality of the data.

Both advantages and disadvantages exist in collecting data by means of online interviews. The advantages of online interviewing using videoconferencing technologies overcome some of the inherent challenges in standard face-to-face interviews, including time and financial constraints, spatial and mobility restrictions, and geographic dispersion of research participants (Janghorban, Latifnejad Roudsari, & Taghipour, 2014; Lo Iacono, Symonds, & Brown, 2016).

Several limitations to online interviews were noted. First, online interviews rely on the participants' access to the Internet and to the necessary hardware and software, which can result in the systematic denial of potential participants from particular groups to participate (Deakin &

Wakefield, 2013; Schmidt, 2007). Furthermore, a successful online interview depends on the participants' digital literacy or having sufficient competence to navigate their way through any challenges resulting from using the relevant technologies (Hamilton & Bowers, 2006; O'Connor & Madge, 2001). To mitigate this setback, I provided the participants with clear instructions on how to access, install, and use their chosen videoconferencing technology if they needed assistance before the interview. All study participants were familiar with either one of the technologies and no issues were encountered. Even when the researchers and interview participants have no issues with accessing and using the relevant technologies, there is the possibility of connectivity problems that can interfere with the flow of an interview, and make it necessary to have a contingency plan that is acceptable to the study participants (Fox, Morris, & Rumsey, 2008; Salmons, 2015). I did not encounter any major technical issues that interfered with the quality of the research interviews.

Another disadvantage of online interviewing using videoconferencing technologies is related to the head shot view captured by the webcam (Bayles, 2012). Although videoconferencing technologies allow the researchers to detect both verbal and non-verbal cues, it is not possible to observe all the body movements and posture of the participants. Lastly, in online interviews, the researchers have no control over the interview setting where the participants are taking part in the interview. Murray and Sixsmith (1998) claimed that the setting may influence the research participants' responses because of surrounding distractions or lack of privacy. I encourage the study participants to have the interview in a quiet and private space; however, the decision was ultimately up to the participants. This issue has ethical implications that are addressed later on in this chapter.

Data Analysis Methods

In the study, I drew upon the analytical methods and procedures proceeding from constructivist grounded theory. In grounded theory in general, data analysis begins the moment the researchers go into the field and start collecting first-hand data. Analytic ideas may be triggered by the researcher's observations of the setting, the participant(s), and the interactions during an interview or a field observation. Charmaz (2014) suggested using memos to keep record of any analytical thoughts sparked by observations made during data-gathering or while transcribing interview recording. These ideas can be followed up and developed later on in the research process.

I transcribed the interview recordings immediately after each interview so that I could start data analysis without delay. Classical and constructivist grounded theorists hold differing views about whether interviews should be recorded and transcribed (Charmaz, 2014; Glaser, 1978, 1998). Glaser (1978, 1998) favored taking notes to record the salient points of an interview, thereby avoiding getting lost in needless details. Coding from notes allows researchers to gain a wider view of the data and expedite the transition to theoretical abstraction (Charmaz, 2014). On the other hand, Charmaz (2014) documented several advantages associated with transcribing. Transcribing interviews helps to preserve not only the details of the exchange but also the construction of the interviews themselves. Coding full transcriptions allows the researchers to engage with the data at a deeper level. In the study, interview transcribing was followed by coding.

Coding lies at the heart of data analysis in grounded theory. It is "the pivotal link between collecting data and developing an emergent theory to explain these data" (Charmaz, 2014, p. 113). Coding involves interrogating the data analytically to illuminate and make sense

of what is happening in the studied world (Charmaz, 2014). Coding provides the analytic frame that supports the entire analysis and the evolving theoretical conceptualizations. This process not only yields an interpretative representation of phenomena; it also informs subsequent data collection through the use of theoretical sampling. Coding in constructivist grounded theory incorporates two stages: initial coding and focused coding (Charmaz, 2014). In some cases, focused coding may be followed by axial or theoretical coding depending on the course of data analysis. The different phases of data analysis are explained in greater detail in the remainder of this section.

Initial Coding

During initial coding the researcher takes the data apart to study them closely for their analytic value. Each segment of the data – words, lines, or incidents – is categorized by a label that concisely defines what that piece of data is about (Charmaz, 2014). The constructed codes represent how the researcher has selected, sorted, and separated the data; they are based on the researcher's understandings and actions. Nevertheless, coding is also an interactive process whereby researchers pursue their earlier interactions with the research participants through their involvement with the transcribed data.

Initial coding is flexible, tentative, and grounded in the data (Charmaz, 2014). By constructing codes that remain close to the data, initial coding preserves the empirical links to the studied world. It also enables researchers to entertain different analytic possibilities and theoretical directions to see where they lead them, as opposed to forcing the data to fit preconceived ideas. Initial coding contributes to the fit and relevance of the emerging grounded theory (Charmaz, 2014). Fit refers to the coherence between the studied world and the

constructed codes, whereas relevance speaks to the acuity of the analytic categories to explain what is happening in the data.

During initial coding, I analyzed interview transcripts using line-by-line coding. When doing line-by-line coding, researchers assign an analytic label to every line of the data (Glaser, 1978). Line-by-line coding was appropriate for doing initial coding in the study because of its suitability to analyze detailed data, such as interview transcripts or detailed field notes (Charmaz, 2014). Line-by-line coding ensures a thorough and textured analysis of the gathered data in the study. Additionally, line-by-line coding enables researchers to look at data critically without getting sucked into the participants' stories and perspectives (Charmaz, 2014). Looking at the data through a different lens can spur analytical insights and ideas to pursue through further data collection. Careful line-by-line coding also demands discipline and prevents researchers from imposing their own preconceptions or values on the data, or "taking off on theoretical flights of fancy" (Charmaz, 2014, p. 125).

The goal of initial coding is to generate codes that are both succinct and precise. I followed the guidelines proposed by Charmaz (2014) for constructing initial codes. First, I constructed codes that stayed close to the transcribed data to avoid veering off from the participants' meanings and perspectives. In some cases, I used in vivo codes as initial codes. In vivo codes use the research participants' own terms as codes, and they thus anchor the emerging analysis into the research participants' perspectives (Charmaz, 2014). I also made sure that the assigned codes captured actions rather than topics or themes. This strategy was originally advanced by Glaser (1978) who suggested coding with gerunds to capture processes and actions and to remain close to the data. Coding with gerunds preserves the dynamic nature of participant experiences and the character of the data (Charmaz, 2014). Additionally, it averts researchers

from making conceptual leaps or uncritically adopting concepts from extant theoretical frameworks. Lastly, I kept the coding process spontaneous and avoided overthinking initial codes.

Throughout the initial coding process, I used comparative methods. During initial coding, constant comparison involved comparing incidents in the data within and across interview transcripts to discern analytic distinctions (Charmaz, 2014). Comparative methods enabled me to detect similarities and nuances in the research participants' meanings, perspectives, and actions.

Focused Coding

Focused coding builds on initial coding and contributes to the theoretical direction of the emerging data analysis. Focused coding is selective and deliberate in that the researcher studies and compares the initial codes to discern the most frequent or salient codes (Charmaz, 2014). These codes are then put to the test by using them to analyze, sort, and synthesize larger volumes of data. Charmaz (2014) characterized this phase as deciding "which initial codes make the most analytic sense to categorize your data incisively and completely" (p. 138). Focused coding thus helps to assess the conceptual import and fitness of the initial codes. In some cases, the researcher may have to construct new codes that can aptly account for several initial codes or to recode the initial codes (Charmaz, 2014).

Focused coding highlights initial codes that have "more theoretical reach, direction, and centrality" (Charmaz, 2014, p. 141), and which are later used to shape the direction of the research process. In so doing, it helps to streamline and expedite the analysis without forgoing its links to the data (Charmaz, 2014). Focused coding also moves the analysis to a higher level of conceptual abstraction. I used focused coding in the study to streamline emerging analytic

concepts, reach a higher level of abstraction, and improve the theoretical sensitivity of the analysis.

Comparative methods are indispensable to focused coding. Focused codes emerge through comparing the initial codes with the data as well as with each other (Charmaz, 2014). Comparative methods help illuminate the theoretical centrality of specific analytic ideas. I adopted a constant comparative approach when I was doing focused coding.

Similar to initial coding, focused coding is interactive, emergent, and flexible (Charmaz, 2014). During focused coding the researcher is actively interacting with the data; researchers are part of the analysis through the application of their analytic skills and their perspectives. Focused coding is an emergent process because it allows fresh insights about the data and the initial codes to surface. Focused coding is also flexible as it gives the researcher the latitude to pursue salient codes while setting aside others; however, these decisions are not absolute. In some studies, initial and focused coding suffice to uncover the central patterns in the data but, in other cases, the researcher may have to resort to axial coding to tighten up the analysis. In the present study, focused coding was followed by theoretical coding.

Theoretical Coding

Theoretical coding is a more sophisticated type of coding that follows focused coding (Charmaz 2014). Glaser (1978) initially introduced the notion of theoretical codes. Theoretical codes frame how the substantive codes may be related to each other in the form of a hypothesis that feeds into the emergent substantive theory. Theoretical codes are integrative and help the researcher create a coherent analytic story that has theoretical potential (Charmaz, 2014). Glaser (1992) maintained that theoretical codes make axial coding redundant because they help to put the story in the data back together. To facilitate the process of theoretical coding, Glaser (1978,

1998) identified theoretical coding families, which are specific analytic frames that subsume conceptual variations related to the larger category. Some grounded theorists borrow theoretical concepts from their discipline or at times from another field (Charmaz, 2014).

Glaser (1978) claimed that theoretical codes are emergent because they proceed from the substantive codes; however, Charmaz (2014) disputed this point. Charmaz questioned the extent to which theoretical coding is an emergent process, as opposed to imposing a theoretical overlay on the data. If theoretical codes are applied indiscriminately, they can stifle the emergence of fresh insights and force the data into old frameworks.

In view of this risk, Charmaz (2014) emphasized that theoretical codes should be implied by the data and the emergent substantive analysis, which means that they must earn their place in the final theoretical product. The author stated that, when used diligently, theoretical codes can provide theoretical direction to the analysis and enhance the analytic power of the grounded theory. In the study, theoretical coding was used to weave emergent categories into a coherent analytic story, and to provide a cogent theoretical direction to the analysis (Charmaz, 2014). Theoretical coding was useful to develop the final theoretical model.

Memo-Writing

As explained at the beginning of this section, I started writing memos while collecting data to keep record of any analytic ideas elicited by my observations during the interviews. During data analysis, memo-writing assumes a focal role in honing the emergent categories and elevating the analytic ideas to higher levels of theoretical abstraction (Charmaz, 2014). Charmaz (2014) defined memo-writing as the "pivotal intermediate step" (p. 162) that bridges data-gathering with data analysis and report-writing. Memo-writing is considered a critical strategy in

grounded theory research because it keeps the researcher involved in data analysis right from the outset and throughout the research process.

Memos are informal analytic notes that capture the researcher's thoughts and questions about the analytic codes and the data (Charmaz, 2014). Memos are used to clarify and flesh out categories by developing and raising the analytic status of focused codes. They provide a space to reflect on the data through comparing data with data, data with codes, codes with codes, codes with categories, and categories with categories. They also prompt the researcher to formulate theoretical conjectures about the emergent categories that can be pursued through focused data-gathering (Charmaz, 2014). Memos thus provide theoretical direction to the analysis.

In the early stages of the analysis, memos are used to report what is happening in the data, explore and develop the qualitative codes, and make analytic speculations about the relationships in the data (Charmaz, 2014). Later on in the analysis, advanced memos are used to define the analytic properties of the categories, elaborate on the processes and variations subsumed by the categories, identify the assumptions that support them, and situate them within an argument. As the analysis progresses, memos tend to become less concrete and more theoretical; however, at all levels of abstraction they must invoke examples from the raw data to ground the emerging analysis and support theoretical claims (Charmaz, 2014). I used memo-writing as an analytic tool to develop and refine emergent categories, and to organize and consolidate the analysis into a coherent theoretical product. An example memo is included in Appendix F.

Data Analysis and Theory Development

Data analysis and theory development were underway from the moment I started conducting initial interviews with the research participants. During data collection, patterns in

the participants' responses within and across interviews, as well as preliminary analytic observations elicited by the interview conversations, were noted and recorded in memos. Interview recordings were transcribed soon after my meetings with each participant. Early transcribing helped me to preserve the details of the exchange and to engage in an ongoing dialogue with the participants, albeit not in person, by going over their responses as I listened to the interview recordings several times. Transcription enabled a close encounter with the participants' words and how they constructed meaning around their experiences. It also promoted deeper analytic insights into how participants were contending with the indelible legacy of historical trauma through community- and society-level interventions with affected communities and populations. While transcribing, I continued recording my analytic thoughts about the data through memo writing. I also made note of ideas and questions that I could follow up later in future interviews. Post-transcription member checking was carried out via email and in some cases continued during the follow-up interviews.

Transcription was immediately followed by formal coding of interview transcripts. I first conducted initial coding by doing line-by-line coding of interview transcripts using gerunds and in vivo codes, which allowed for a systematic and textured analysis of the collected data. I later moved on to focused coding which involved both recoding of initial codes and constructing new codes that captured the essence of several initial codes. Focused coding helped to sort out and synthesize the vast number of initial codes and to streamline the direction of the data analysis. It also helped me to discern relationships and conceptual patterns in the initial codes and move the analysis to a higher level of theoretical abstraction. Constant comparison was indispensable during initial and focused coding. During initial coding, I used comparative methods to compare and contrast incidents in the data within and across interview transcripts (Charmaz, 2014). Later,

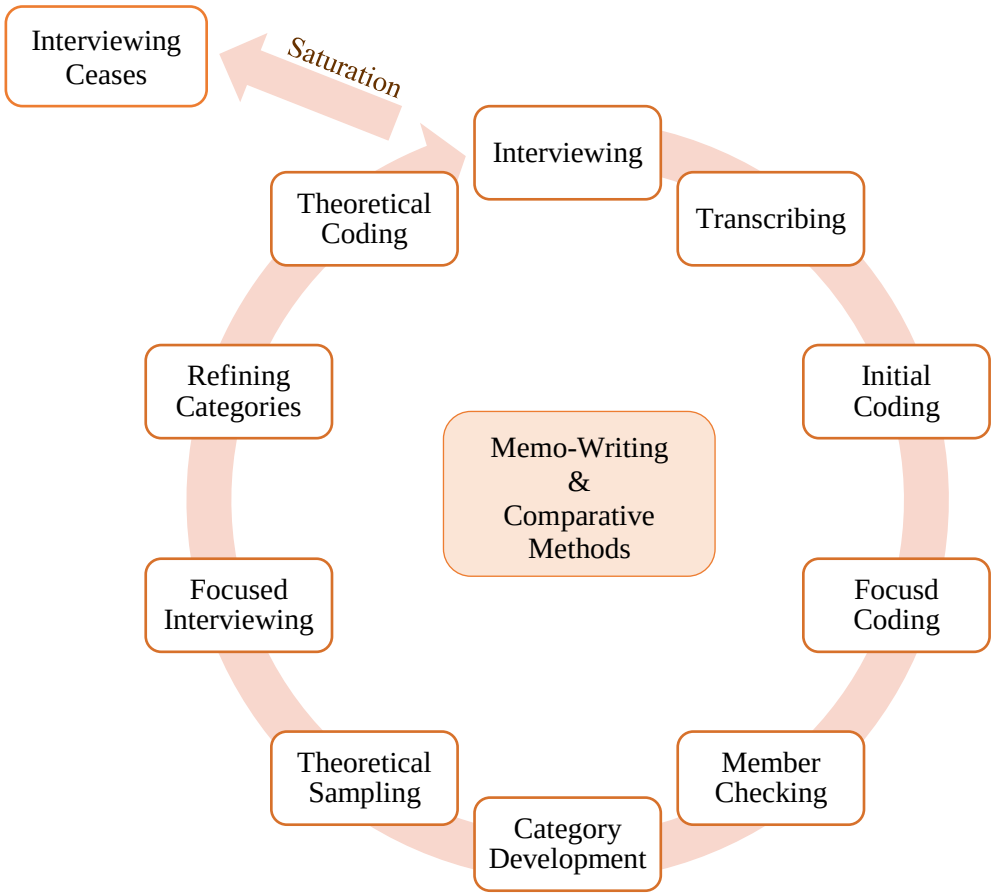
constant comparison facilitated the development of focused codes through comparing the initial codes with the data as well as with each other.

Memo-writing was an essential methodological tool that I used through the coding process to uncover explicit and latent patterns in the data. The constant writing and reviewing of memos helped to clarify, flesh out, and hone focused codes, which eventually were developed into conceptual categories. Memo-writing was also useful to make theoretical speculations about the emergent categories, which I later pursued through theoretical sampling of new participants and follow-up interviews with enrolled participants. Follow-up interviews were conducted with 10 of the 12 participants. Saturation was reached when further data collection did not yield any new theoretical insights into the established analytical categories, which meant that the categories were conceptually well-defined and had stable and clearly articulated properties.

Finally, theoretical coding helped to shape further theory development by framing the relationships among the different conceptual categories into a coherent and integrative analytic story that represented the grounded theory. Follow-up interviews with participants helped to fine-tune and corroborate the final theoretical product. Figure 2 below represents a simplified illustration of the integrated data collection and data analysis process.

Figure 2

Integrated Data Collection and Analysis Process



Criteria and Measures for Quality and Trustworthiness

A fundamental concern in all types of scientific inquiry is whether or not the claims that researchers make about the empirical world are trustworthy (Merriam & Tisdell, 2016). The trustworthiness of research results by and large depends on the degree of rigor with which an investigation is conducted, meaning the quality of the study. In qualitative inquiry, concerns about quality form part of a larger and heated debate over the legitimacy of the knowledge produced by qualitative studies (Mays & Pope, 2006). Because the philosophical assumptions

about the nature of reality and knowledge in qualitative inquiry are inherently different from positivist assumptions, conventional criteria (internal and external validity, reliability, neutrality) to assess quality in quantitative studies are not pertinent for qualitative research (Lincoln & Guba, 1985).

The growing uptake of qualitative methods in applied social sciences and other fields of inquiry, and the emergence of new qualitative approaches, has led to the proliferation of guidelines and alternative criteria to judge the rigor of qualitative designs (Ezzy, 2002; Mays & Pope, 2006; Merriam & Tisdell, 2016). Some of the proposed quality guidelines have reframed conventional criteria adopted in quantitative research to make them applicable for qualitative inquiry (e.g. Lincoln & Guba, 1985). On the other hand, various interpretative researchers resisted altogether the influence of positivism, and instead developed new sets of criteria that reflect the unique language of qualitative inquiry (e.g. Eisner, 1998; Gubrium and Holstein, 1997). The influence of feminism, postmodernism, and poststructuralism have added other dimensions to the assessment of quality in qualitative research (Ezzy, 2002; Merriam & Tisdell, 2016). Researchers influenced by these schools of thought espoused the political nature of social research, and hence argued for the inclusion of political action and participant involvement in their assessments of quality (e.g. Lincoln, 1995; Richardson & St. Pierre, 2005). From this perspective, rigorous research is also ethical research, and therefore it must demonstrate a commitment to the participants' voices, and to justice, dignity, and collaboration (Ezzy, 2002). The epistemological dispute over how to ascertain rigor in qualitative research remains unresolved, primarily because of the underlying lack of consensus about what constitutes qualitative research (Denzin & Lincoln, 2018; Mays & Pope, 2006). As a result there is no definitive set of criteria to determine quality in qualitative research.

In the study, I followed the criteria established by Lincoln and Guba (1985), which include credibility, transferability, dependability, and confirmability, as well as some of the criteria identified by Lincoln (1995) that speak to the more recent developments and influences in social scientific inquiry: critical subjectivity, positionality, voice, and sacredness. My decision to adopt these criteria in lieu of other quality measures was based on the utility and applicability of these criteria to the study at hand. This argument was offered by Lincoln (1995), who acknowledged that certain criteria may be appropriate to specific kinds of research, but may have limited value in other types of inquiry. Although several postmodern scholars have rejected Lincoln and Guba's (1985) criteria on the basis of their affinity to positivist thinking and rigid dualism (Smith, 1993; Schwandt, 1996), the concepts of credibility, transferability, dependability, and confirmability are nonetheless still regarded as useful to institute methodological rigor (Ezzy, 2002; Lincoln, Lynham, & Guba, 2011). These criteria are congruent with the post-positivist roots of grounded theory and the research methods that were used in the study. Critical subjectivity, positionality, voice, and sacredness (Lincoln, 1995) aligned with the constructivist orientation of the study. The criteria and the corresponding measures that were implemented to ensure rigor and the trustworthiness of the research findings are discussed in the remainder of this section.

Credibility

Credibility means that the research findings are coherent and authentically reconstruct the multiplicity and complexity of the participants' meanings and interpretations (Lincoln & Guba, 1985). Credibility is the qualitative counterpart of internal validity in quantitative research. To ensure the credibility of the study's theoretical constructs, I relied on three strategies: adequate engagement in data-gathering, member checking, and peer debriefing (Lincoln & Guba, 1985).

Adequate engagement in data-gathering. Adequate engagement in data-gathering enables the researchers to get a good handle on how the study participants make sense of the studied phenomenon and how they engage with it by way of their actions in the social world (Merriam & Tisdell, 2016). In the study, the objective to reach theoretical saturation precluded me from prematurely ceasing data collection and analysis (Charmaz, 2014). Theoretical saturation helped ensure that I spent sufficient time collecting data to fully saturate the emergent theoretical categories, so that they were conceptually well developed with clearly articulated properties.

Member-checking. Member checking, also known as respondent validation, involves consulting with the study participants to verify that the researcher's analytic interpretations and reporting faithfully reconstruct the participants' meanings and actions (Lincoln & Guba, 1985). As part of member checking, I presented the participants with their interview transcript after every interview. This measure allowed the participants to corroborate the contents of the transcript and to volunteer additional information if they wanted to clarify or expound on certain statements or discussion points. Additionally, I sought feedback about the emergent categories from a small group of three participants to ascertain that my analytic interpretations accurately capture their understandings, perspectives, and actions, and resonate with their lived experiences and points of view (Lincoln & Guba, 1985). In grounded theory studies, member checking is also made possible through theoretical sampling and the integrated and iterative nature of data collection and analysis. These features allowed me to check any analytic insights gleaned from an interview participant with the same and other research participants (Lincoln & Guba, 1985)

Peer debriefing. Peer debriefing or peer review is another strategy to establish the credibility of the research results. In peer review, the researchers solicit the feedback of a

"disinterested peer" (Lincoln & Guba, 1985, p. 308) to weigh in on the researchers' interpretations of the data and other aspects of the inquiry. I nominated a doctoral graduate to serve as a peer reviewer for the study. The peer reviewer had experience in qualitative research and data analysis, and was interested in the topic of the study. The peer reviewer: (a) independently coded two anonymized interview transcripts that had been coded already to compare and contrast the analytic codes (Patton, 2015); (b) helped me revisit and interrogate my analytic interpretations (Lincoln & Guba, 1985); (c) provided feedback about the conceptual clarity of the analytic categories and the theoretical direction of the analysis; and (d) probed any implicit values, biases and preconceptions that were clouding my analytic judgement (Lincoln & Guba, 1985). Minor discrepancies were noted and discussed, and the feedback from the peer reviewer was used to revise and tighten up the data analysis.

Transferability

Lincoln and Guba (1985) defined transferability as the extent to which the findings of one study can be applied to other contexts. The concept of transferability complements the construct of external validity in quantitative inquiry. Lincoln & Guba (1985) emphasized that the onus of determining the transferability of research results lies more with the researchers who are seeking application of the findings elsewhere than with the original investigators. In the study, I facilitated transferability by providing "thick descriptions" (Lincoln & Guba, 1985, p. 135), or a detailed presentation of the participants' characteristics and situational factors, to enable the readers and other researchers to contextualize the findings and judge for themselves their transferability to other settings.

Dependability

Dependability relates to the consistency of the research process by which the study results are obtained (Lincoln & Guba, 1985). Dependability is akin to the concept of reliability in quantitative research. In this study, dependability was ascertained by developing an audit trail. As part of the audit trail, a clear account of the research steps undertaken in the study was provided to enable the readers to judge the process upon which analytic inferences were drawn. Additionally, I kept a methodological log to document methodological decisions and the concomitant rationales (Lincoln & Guba, 1985).

Confirmability

Confirmability is the extent to which the research findings represent the participants' meanings and perspectives as attested by the data instead of the researcher's subjective viewpoints (Lincoln & Guba, 1985). The concept of confirmability runs parallel to the construct of neutrality or objectivity. In the study, confirmability was primarily secured via the audit trail, which will illustrate my analytic journey starting from the raw data, continuing with how the theoretical categories were derived, and finishing with the study implications and recommendations (Lincoln & Guba, 2015). An audit trail enables auditors to assess the confirmability of analytic interpretations and inferences. As part of the audit trail, I provided a supporting evidence related to the synthesis of the final theoretical product.

Confirmability was further ascertained by grounding my interpretations in the data, also referred to as "grounding in examples" (Elliott, Constance, & Rennie, 1999, p. 223). Verbatim quotations were used to support my analytic process and conclusions. This will allow the readers to judge whether my interpretations of the data are analytically sound and corroborated by the raw data.

Critical Subjectivity

Critical subjectivity or reflexivity involves the researcher's commitment to reflect on one's beliefs, values, preconceptions, and feelings before, during, and after conducting the study (Lincoln, 1995). This process enables researchers to become cognizant of how they influence and are influenced by the research (Probst & Berenson, 2014). The concept of critical reflexivity recognizes how meaningful research experiences can promote personal and social transformations. To aid this process, I used of a reflexive journal throughout the study to articulate my thoughts, assumptions, interests, and emotions in relation to the research process. The journal helped me gain insight into my impact on the research process and its impact on me, and how the study findings can be used to advocate for the well-being of communities and groups affected by historical trauma. Keeping a reflexive journal also assisted with the confirmability of the research findings and to reflect on my positionality as a researcher.

Positionality

Positionality is concerned with both the researchers' epistemological stance as well as their worldview, theoretical orientation, and their relationship to the studied phenomenon (Lincoln, 1995, Merriam & Tisdell, 2016). Feminist theory, postmodernism, and poststructuralism postulate that texts are "socially, culturally, historically, racially, and sexually located" (Lincoln, 1995, p. 280). I addressed this criterion by stating my positionality, including my motivations to research the topic of historical trauma and collective interventions, my assumptions on the subject, and my theoretical and epistemological orientations at the outset of the study. By making my positionality explicit, I enhanced the authenticity of the study (Lincoln, 1995, Merriam & Tisdell, 2016).

Voice and Sacredness

Voice is related to the researcher's commitment to honor and draw out the research participants' voices, especially the voices of individuals who are representative of groups that are traditionally disenfranchised in society (Lincoln, 1995). Sacredness stems from the researcher's profound respect for the human condition, human rights, justice, and reciprocity, which translates into egalitarian research relationships and an action-oriented research focus. In the study, I shed light on how mental health practitioners can respond to the plight of historically oppressed populations that carry the burden of historical trauma. It was my hope that the study serves to promote compassion, respect, and justice for disenfranchised groups, and to identify ways to redress the historical harms of long-term political violence and subjugation.

As the influence of feminist and postmodern theory blurs the rigid distinctions between rigor and ethics, critical subjectivity, positionality, voice, and sacredness serve not only as quality criteria but as ethical standards that address the political implications of my research (Ezzy, 2002; Lincoln, 1995). Ethical research is more than a procedural concern; it is grounded in a profound respect for others and a commitment to justice. In the next section, I discuss the ethical procedures that will be followed in the study.

Ethical Considerations

Paying attention to ethical issues and seeking ethical scrutiny not only protects participants and their rights, it also leads to sounder research (Napier, 2005). As a researcher and a counseling professional, I followed the legal requirements set out by the Unites States Code of Federal Regulations (45 CFR 46) and the American Counseling Association (ACA, 2014) *Code of Ethics*. When addressing the legal and ethical issues associated with a research study, four

areas need to be considered, which are referred to as the four Cs: conduct, consent, confidentiality, and competence (Napier, 2005).

Research Conduct

The National Research Act of 1974 and the associated Federal Regulations for the Protection of Human Subjects (45 CFR 46), under the authority of the Office for Human Research Protections, require public and private institutions engaged in federally-supported research to establish committees to approve and oversee research projects involving human subjects, to ensure that human participants are protected (Maloney, 1984). The University Committee for the Protection of Human Subjects in Research at the University of New Orleans conducts its research oversight and compliance in accordance with the United States Code of Federal Regulations (45 CFR 46), and is guided by the ethical principles set forth in the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). As explained earlier in this chapter, I submitted my research proposal to the institutional review board (IRB) at the University of New Orleans to seek approval to conduct the study. Once the study was approved, I abided by the research protocol endorsed by the IRB.

Informed Consent

Obtaining informed consent is imperative when conducting research with human participants and is also mandated by the *ACA Code of Ethics* (2014, §G.2.a). Informed consent means that the research participants give and continue to give a valid consent to take part in a study (Napier, 2005). It also implies that they understand what the research is about, what their participation entails, the likely outcomes of the study, and any risks they might incur as a result of their involvement in the study.

All prospective participants received an invitation that included an informed consent letter. The informed consent letter provided details about the following: (a) the purpose and design of the research study; (b) the nature of participant involvement in the study, including what will be required of them if they decide to participate in the study and the procedures that will be followed; (c) the expected benefits associated with their participation; (d) the potential discomforts and risks involved in taking part in the study; (e) their right to confidentiality, including how it will be protected and any limitations to confidentiality; (f) their freedom to not participate in the study and to withdraw their consent and discontinue their participation at any time without penalty; (g) how the research results will be reported and disseminated, and the target audience; and (h) their right to have their questions concerning their involvement in the study and the study procedures answered satisfactorily. Potential participants who decided to take part in the study were asked to sign the informed consent, which signified that they had read and understood the contents of the informed consent letter and confirming their agreement to participate in the research project.

Voluntary participation. Participation in the study was voluntary meaning that participants were free to choose whether or not to engage in the project, without inducement, penalty, or loss of benefits. The Federal Regulations for the Protection of Human Subjects (45 CFR 46, §46.116) stipulate that informed consent should include a statement that clarifies the voluntary nature of participation in the research.

Expected benefits. The expected benefits associated with the present study were considered internal (Wilkinson & McNeil, 1996). The research participants were informed that their involvement in the study will contribute toward a better understanding of how mental health practitioners can intervene to support and empower populations affected by historical trauma

through collective interventions. Through their participation, the study participants made a valuable contribution to a field that is in much need of more empirical research.

Potential discomfort and risks. Involvement in the study posed minimal risks to the research participants. Although the subject of historical trauma can be sensitive territory for those affected, the purpose of the study was not to learn about the participants' personal struggles with historical trauma. The interview questions focused on their interventions with impacted populations. Nevertheless, it was important to acknowledge the likelihood that participating mental health practitioners belonged to the same cultural groups affected by historical trauma. This possibility implied that the study participants may have experienced the effects of historical trauma in their lives or the lives of significant others. I was therefore mindful of any potential distress that may have result from taking part in the interviews (Legerski & Bunnell, 2010).

As a measure to protect the study participants from potential harm and emotional stress (ACA 2014, §G.1.e), research interviewees were informed that they could stop the interview immediately if they felt distressed. Additionally, if I noticed that an interviewee was getting distressed, I would have brought my observations to the participant's attention. The participant could then choose to either continue or end the interview. At the end of every interview, I asked the participants how they felt about their interview experience. None of the participants felt distressed during the interviews. As a qualitative researcher, I believe it is a privilege to enter the participants' world, but this privilege carries inherent responsibilities. Bearing witness to the participants' stories and realities necessitates an attitude of respect, compassion, and humility. Treating research participants with respect is a cornerstone of ethical research conduct (Napier, 2005).

Participant Confidentiality and Anonymity

Protecting the confidentiality and anonymity of research participants is another fundamental ethical obligation in research that is also emphasized in the *ACA Code of Ethics* (2014, §G.2.d). In the study, the research participants were informed on how their data will be stored, used, and shared. All data was collected and stored in accordance with the Federal Regulations for the Protection of Human Subjects (45 CFR 46). Participant data, including interview recordings and transcripts, will be encrypted and stored securely in a password protected computer that can be accessed only by me. Interview recordings will be destroyed at the end of the investigation.

Participant involvement in the study will be kept anonymous and participants will not be identifiable in any document or report subsequently produced after completing the study, unless requested otherwise by the participant. Participant names and any other personal identifiers were changed or removed from the interview transcripts. In qualitative research, participant anonymity is a thorny issue, particularly when participants belong to a small target population, which could make identification possible by means of deductive disclosure (Wiles, Crow, Heath, & Charles, 2008). Because only a small number of mental health practitioners have been involved in delivering collective historical trauma interventions, additional measures were undertaken to safeguard participant anonymity, such as by checking directly with the participants about specific information that might have given away their identity. Research participants had a say in how their data is used and reported. I entered into an ongoing dialogue with the participants about how they preferred their data to be used and presented. All participants were provided with a plan on the use of their data, including how the findings will be disseminated,

the target audience for the study results, and the use of anonymized quotes or interview transcripts in publications (Kaiser, 2009).

It must be noted that I had no control over the settings where participants decided to have the interviews because of the online nature of data gathering in the present study. This decision was at the participants' discretion. Nevertheless, I recommended to the participants to choose a safe and private space.

Researcher's Competence

The researcher's competence is another aspect that needs to be considered when planning a research study. The researcher or research team must possess the necessary competences to undertake the project and follow through to its successful completion (Napier, 2005). As a researcher, I have contributed to several research projects in the past and have experience conducting both face-to-face and online research interviews. Additionally, throughout the study, I had the academic support of my major advisor and the members of the dissertation committee.

Another important ethical consideration pertaining to the researcher's competence is associated with the cross-cultural nature of the study. All of my exchanges with the research participants constituted a cross-cultural encounter. Cross-cultural competency was key to developing respectful and dignifying relationships with the study participants. Cross-cultural competency entails having the necessary awareness, knowledge, and skills to develop effective working alliances with individuals from diverse cultural backgrounds (Lee & Park, 2013). Although my training as a counselor came in handy to navigate the complexities of cross-cultural transactions, I relied on books and Internet resources to broaden my knowledge of the participants' culture and cultural history prior to conducting the interviews.

Chapter Summary

I started this chapter with a review of the research questions and objectives. I then provided a detailed description of the study design, research methodology, sampling strategy, and participant recruitment procedures, as well as the rationale for the proposed methodological choices. In this chapter, I also covered the role of the researcher in the study, including the researcher's frame of reference, assumptions, theoretical orientation, and experiences relevant to the research topic. I concluded with an overview of the measures that will be undertaken to ascertain rigor and trustworthiness of the study results and the ethical considerations.

CHAPTER IV

RESULTS

Historical trauma can have adverse impacts not only on individual well-being, but also on family functioning and the social fabric of communities and societies. Consequently, an individualized approach to redress the legacy effects of historical trauma is inadequate unless combined with community- and society-level interventions. The need to adopt a multilevel approach to mitigate the broader repercussions of historical trauma that takes into account individuals, families, and communities is starting to gain traction among psychological trauma scholars and mental health practitioners (Evans-Campbell, 2008; Hoffman & Kruczek, 2011; Somasundaram, 2014). Collective interventions hold promise for addressing the collective and multilayered impacts of historical trauma despite the paucity of empirical research in this area, especially in the field of counseling. The purpose of the present study was to examine how mental health practitioners address the impacts of historical trauma at the community and society levels, and to explore the functions that mental health counselors can assume in collective historical trauma interventions.

Drawing on a constructivist research paradigm, I applied constructivist grounded theory methods to develop a theoretical model that explains how mental health practitioners address the legacy effects of historical trauma through community-based and society-level interventions. The model represents a co-constructed theoretical product that reflects the plurality of the participants' voices, experiences, perspectives, and social realities. The model captures core aspects of the work that the participants did or are doing to help communities and societies address the legacy of historical trauma. It also elucidates key professional attitudes, knowledge

and behaviors that mental health practitioners must develop and possess in order to deliver effective community-based and society-level interventions for historical trauma.

I start this chapter by introducing the participants who took part in the study. I describe their practice settings and work within and beyond their communities, and include relevant information that provides the readers with additional context to make sense of the results and my interpretations. The findings of the study are presented next. I first provide a step-by-step account of how I arrived at the conceptual categories and the final theoretical model, and then provide a detailed explanation of the components that make up the grounded theory. I conclude the chapter with summary of the findings.

Participants

In this section, I introduce the 12 participants who joined the study. I developed an individualized profile for each of the participants. Participants' verbatim quotations from the interview transcripts are included to illustrate the participants' perspectives and experiences in connection with the topic of the study.

All study participants had direct experience working with populations affected by historical trauma and practical experience in delivering community-based and/or society-level interventions to address the historical trauma. Although not all of the participants were registered mental health practitioners, they had all worked in the field of trauma healing and historical trauma for many years, and most of them had received formal training in trauma awareness and healing. Table 1 on the next page presents the participants' demographic information.

Table 1

Participant Demographic Information

Participant assigned pseudonym	Nationality	Race/Ethnicity	Gender	Age bracket	Profession	Years of experience in the field of historical trauma	Licensed mental health practitioner (Yes/No)
Emma	Australian	Aboriginal, European	Female	71–80	Trauma specialist, educator	> 30	No
Ezra	United States	African American	Male	61–70	Practitioner, scholar, educator	> 30	No
Johanna	Canadian	European Canadian	Female	31–40	Mental health counselor	> 10	Yes
Julia	United States	European American	Female	41–50	Peacebuilder, educator	> 20	No
Kevin	Canadian	First Nations	Male	61–70	Social worker, scholar	> 30	Yes
Maya	United States	Asian American	Female	41–50	Practitioner, educator	≈ 10	No
Nathalie	United States	Native American, European	Female	71–80	Community interventionist, psychologist, scholar, educator	> 40	Yes
Pablo	United States	European American	Male	81–90	Psychiatrist, psychoanalyst	> 40	Yes
Renata	United States	Asian American	Female	31–40	Practitioner, leadership and organizational consultant	> 10	No
Simone	Canadian	European Canadian	Female	41–50	Mental health counselor, clinical supervisor, educator	> 10	Yes
Wendy	Canadian	First Nations	Female	61–70	Practitioner, scholar, educator	> 30	No
Zora	South African	Black South African	Female	41–50	Social worker, scholar, educator	> 10	Yes

Emma

Emma is an Australian qualified trauma specialist and educator who has an Aboriginal and European heritage. She has over 30 years' experience working with countless Aboriginal communities across Australia and abroad on violence, trauma, and healing. Additionally, Emma worked in academia teaching indigenous studies. She continues to work in communities and contribute to the literature on community-based violence, relational trauma, and healing for Indigenous peoples. Emma has a doctoral degree in cross-cultural psychology.

Emma claimed that Australia was turned into a war zone from the moment the first colonial ship sailed into Sydney Cove. She pointed out the enduring consequences that the violence of colonization had on Aboriginal peoples, such as high rates of suicide, especially among young men, sexual abuse, and domestic violence. Emma argued that the violence that comes into a system, such as a family or community, stays in the system. "The point I'm making here is that violence that comes in, stays in. And it will be the despair, the rage, the anger, but it's turned inwards and then turned on those closest to us." She explained that powerlessness and shame are the most pernicious manifestations of historical trauma.

> One of the biggest factors that I am seeing out of the colonial context is the embodiment of shame. 'I am Black. I am not White. I am bad. White is good. We could not defend ourselves. The men could not defend their women and children.' So that's all part of what is happening, even today.

Emma provided several examples of her collective interventions to address the legacy of historical trauma in Aboriginal communities and communities outside Australia, and throughout the interview she illustrated her arguments through stories. Her work in communities is informed by narrative approaches and literature from culturally diverse groups. Story-telling is

central to her practice. She consistently integrates expressive arts, including music, theatre, dance, and painting, in her interventions to help people convey their story and to bring fun and laughter into the work. Most of her community-based interventions are delivered in a large-group format. She describes her style of intervention as an "indigenist healing approach" because it draws on the deep cultural healing practices and rituals of Indigenous communities. Emma explained that usually it is the communities themselves that reach out to her for assistance to address a specific community problem.

> Very rarely do I get an invitation by government to do things. I get invitations by communities. And that's powerful. … The community knows that it has to do something for itself, but it feels powerless. So, they kind of talk around and next thing I get a phone call, "Can you come?"

Emma believes that her role as a practitioner is to hold the space for community members to speak their truth and name the problems with which they are grappling. She pointed out that when people are ready to face and speak their truth, they start feeling empowered to work through the issues and find ways to prevent those same harms from happening again. Emma also stressed the importance of deep listening and letting the community members lead the way. She believes that communities have the solutions to their problems and have the power to rewrite their story. "It's like the answers are in the community, the answers are in the people. … We have to be responsible as clinicians, as practitioners. <u>We have to get rid of our ego and think we've got the answers</u> [emphasis]."

Emma believes that symptoms cast a light on history. A central aspect of her work in communities is helping people understand how their current situation and challenges tie into the wider history of their community.

> I think it was Richard Mollica from Harvard University that introduced me to the three words, symptom is history. … So, when I see the symptoms, I'm wanting to map that with the community history. And that's an educational program to them, a process for them, because they don't know their own history a lot of the times.

As part of her interventions, she also helps people realize how the violence coming from the outside becomes trapped within the system and ends up being acted out on each other. Additionally, Emma educates community members about their rights under the United Nations by pointing them to documents like the Universal Declaration of Human Rights (UDHR), the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). She explained that when people begin to make sense of their situation through a historical lens and gain an understanding of their rights, they develop a sense of agency and start demanding social and political transformations from their governments and institutions.

> It's like, how do I create the capacity for social groups to analyze their own situation, to name and know what's happened historically, so that the historic trauma then fits into the human rights they have under the UN declarations. And so what they're saying to their government is, 'We want this. We want the police to be doing this. We want the Health Department to be doing this.'

Emma considers community members as the principal allies in this work. "So the community itself is a collaborator. It becomes its own change agent." She also works closely with other practitioners who are already serving in that community, such as schoolteachers and physicians. Emma criticized governments for failing to listen and respond to the needs of the

people. “Most of the time, government does not want to hear the truth. So, I don't believe any more that government has the answers and they will deliver. I believe people will deliver.”

Ezra

Ezra is an African American scholar, practitioner, and advocate with over 30 years’ experience in the fields of conflict transformation, post-conflict community reconciliation, and multigenerational trauma. He has mediated numerous multi-party conflicts and has worked with communities, governments, and non-profit and civil society organizations. In the United States, Ezra participated in a national project that helped to initiate and facilitate dialogue between descendants of former enslaved people and descendants of former slaveholders. Ezra has also conducted several workshops and served as a consultant in the United States and abroad. Ezra currently works as a faculty member in an academic setting. Over the years, he has taught graduate courses in negotiation, mediation, conflict resolution, conflict transformation, conflict analysis, and trauma healing. Additionally, he sits on a number of boards of civil societies, and continues to practice and consult in communities and organizations. Earlier in his career, Ezra worked as a community psychologist providing individual, family, and group counseling.

Ezra believes that colonialism is the progenitor of much of the historical trauma affecting diverse populations across the globe. He explained how colonial histories forge distinctive identities and behavioral patterns in a culture or society. “Traumagenic circumstances shaped and reshaped beliefs, and then patterns and practices, and relational patterns, such that we've now organized our society in ways that don't support everyone's full flourishing.” Ezra argued that the goal of his interventions is not to heal or undo historical trauma, but to address contemporary manifestations that are producing distress today. Looking back on history is important insofar as it sheds light on the historical roots of current social issues and challenges. “So that's the whole

reason we do an “archaeological” investigation. To understand the historical sources of the present-day harms. It's not to undo them.”

Ezra’s interventions in communities and organizations fall under the realm of narrative approaches, because it is “the narrative and the discourse, usually that we can't see, that shape institutional structures that shape relationships that identify and determine the distribution of resources, and testimonial authority, and power in a community.” Ezra believes that everyone, including individuals who identify themselves as members of a historically marginalized group and individuals whose identity is tied to a dominant group, are involuntarily behaving in alignment with the same toxic narrative. Over time, people begin to ascribe certain behavioral patterns as cultural, “but it's only cultural because it was a collective response to historically traumagenic circumstances.”

In his interventions, Ezra invites community representatives to the table to uncover and discuss where in history the problematic social patterns emerged. This approach helps people to recognize that none of the observable social patterns are naturally occurring or immutable. He also encourages people to identify counter-narratives that are more supportive of everyone’s well-being and full flourishing, but which are currently being overshadowed by a dominant oppressive narrative. Ezra explained that a key aspect of his work is to get people to interrogate and re-orient how they make meaning of their present circumstances. Consequently, people start feeling empowered to change their actions and behaviors in support of their preferred counter-narrative. Over time, the dominant narrative will grow weaker in its influence.

Ezra described two frameworks that he designed to facilitate conversations in communities that are stuck in historical trauma patterns. He developed these methods as part of his doctoral dissertation, and both are steeped in narrative approaches. The first model is

intended to guide community members to name what is problematic in their current situation and to expose the background story that plays into the problematic conditions and circumstances. People are then invited to identify stories that contradict or do not conform to the dominant narrative. Finally, participants are asked to think about what they can do to reinforce the narrative that reflects how they would like their community to evolve, which "becomes the basis for the social agenda." The second model is based on the ORID (observation-reflection-interpretation-decision) model. This latter framework is predicated on the assumption that the artificial distinction between feelings and meaning making obscures the source of a narrative. Narratives determine how people feel and make sense of the world around them. As part of this process, community representatives are asked to discuss their observations of their social environment and then tell a story that captures how they make meaning of those observations. Historical trauma elements are usually embedded in the story. He then asks people to single out stories that do not fit the identified meaning making pattern, although the stories are based on similar observations. "Is there another story that you can draw from, that you're aware of, that gives you greater agency and ability to respond so that this doesn't remain a problem story?" When people realize that they can construct alternative meanings, they are able to access their sense of agency. Ezra provided examples of how he used these frameworks in real-life settings in the United States and in South Sudan. He emphasized the role of networking and network analysis to identify important community players to join the conversation before implementing either of these two frameworks within the community.

Ezra stated that his methods differ from standard reconciliation efforts. In reconciliation, the focus is on "What harm was caused? Who's responsible for it?" In his works he emphasizes that, "The problem is the problem, and people aren't the problem. And therefore what do we

need to do to shift the narrative and recreate systems and structures in ways that… increase the likelihood that people will experience full flourishing." Ezra explained that his methods are sometimes not received well by people whose style of social organizing centers on making people wrong. His approach is designed to rally allies who want to change the status quo and advocate for social and political transformations. Ezra explained that one of the inherent challenges in his approach is the energy it takes to engage people who are deeply suffering and have "organize[d] their lives around this other as the enemy," and thus cannot see an alternative path to address their predicament.

Johanna

Johanna is a White Canadian Certified Counsellor who has close to 10 years' experience working with children, youth, and families on intergenerational/historical trauma, substance abuse, and domestic violence, and sexual abuse. She runs a private practice in the Northwest Canada and provides mental health services under the Health Canada's Indian Residential School Support Program, serving several Indigenous communities in North Canada. Additionally, Johanna travels to remote communities where she works out of local health centers, child protection offices, and schools. She adopts a multimodal approach in her practice and her work is informed by various psychotherapeutic approaches, such as CBT, DBT, and EMDR, as well as holistic and experiential modalities.

Johanna talked about the colonial histories of the different Indigenous communities that she works in and the legacy effects that continue to have a significant impact on the lives of individuals and families, such as the elevated rates of alcohol abuse and the high incidence of lateral violence at both the family and community levels. She explained that in some remote communities, the family and community dynamics add another layer of challenges that similarly

echo the profound historical wounds sustained by these cultures. In remote close-knit communities, shame can be extremely prevalent and debilitating. Families tend to be more closed to the outside world, and often there is a lot of stigma around reaching out for help. There is a "defensive perception that if we were to address it [the problem], then the whole family would lose face." Sometimes communities may not be ready to acknowledge what is really happening, and as a result, community members tend to turn a blind eye when they notice that an individual or a family is struggling.

Additionally, some people fear being punished by other community members for seeking and accepting outside help. Johanna pointed out that in some cases, community members are trying to shield fellow members from being let down or even abused by service providers, based on their own experiences. She also mentioned that in some of the remote communities, there is a strong and pervasive sense of betrayal and distrust toward White people in general, including mental health workers. Seeking outside support or following a path that does not align with the community's traditional way of life may at times be perceived as undermining the community's efforts toward autonomy and self-determination. Johanna also drew attention to the harsh environmental invalidations that people in some of these remote areas face. "Up in the North, it is very survivalist. You are alone a lot, in very challenging conditions like -40 degrees Celsius. Eight months out of the year, [there is] very little sunlight."

Johanna stated that the phenomenon of learned helplessness comes up frequently in her work. Consequently, most of her clinical interventions are aimed toward encouraging clients and building their skills and resources. Another important component of her work is supporting clients in making safer choices and decisions. In her work, Johanna tries as much as possible to

rely on other community service providers and Indigenous counselors and resources. She believes it is extremely important that clients are connected to Indigenous services and resources.

For some time, Johanna used to visit schools and deliver presentations to school-aged children on Indigenous people who had beaten the odds and become successful. The intended objectives of this school-based intervention were to showcase the achievements of Indigenous people who succeeded in life and contributed to their community, to inspire children to think about their future, and to encourage them to consider various opportunities that may not exist right in front of them at that moment. Johanna explained that in some remote contexts, people have limited access to adequate educational and mental health services and resources, which hinders people's ability to envision a better future for themselves and their families. She noted that the behavioral health system in some of these remote communities is very fragile, usually manned by a skeleton staff of child protection workers and social workers who are relentlessly "putting out fires" and attending to basic needs such as food and clothing.

Johanna expressed that she would like to deliver more collective interventions, such as group therapy. She explained that building trust with community leaders and members is essential prior to delivering successful collective interventions, especially as a White mental health provider. She added that building trust would take a lot of time and patience. She also expressed concerns around safeguarding the confidentiality of group members in small towns where everyone knows each other, and thus it is highly likely that group members would bump into each other outside of therapy.

Johanna expressed that working as a lone provider in remote communities can be extremely intense and exhausting, and emphasized the importance of self-care and clinical supervision. Burnout is very common among service providers working in these areas, which

results in a high turnover. She would like to offer clinical supervision to Indigenous counselors in the future. Johanna feels that her work represents her share of contributing to the reconciliation efforts that are currently underway in Canada. She is also interested in working more closely with Indigenous healers and in being part of a working alliance with other service providers and community leaders that focuses on community development. Outside of her clinic, Johanna participates in advocacy initiatives that promote the rights of Indigenous peoples in Canada.

Julia

Julia is a White American peacebuilder who currently works for a United States-based non-profit organization that supports post-conflict communities to engage in trauma healing, development, and peacebuilding using the inside-out approach. Julia has over 20 years' experience in peacebuilding facilitation, mediation, trauma healing, and program and process design. She has served on numerous projects in the United States and abroad. She has delivered training on trauma awareness and resilience, mediation, and conflict resolution.

Julia claimed that the phenomenon of historical trauma is complex because the traumagenic circumstances are not relegated to some distant past, but traumagenic systems and behaviors are still in effect in the present, which perpetuate the cycle of violence and trauma into the future. Julia argued that it is important to call out historical trauma because it enables people to make sense of what they are experiencing right now in their bodies, lives, cultures, communities, and countries, and even at the international level, and to recognize where these experiences originated. She explained that, "as long as the stuff is invisible and we can't name it, we can't see it, we can't recognize it, and be aware of it, it will just continue."

Julia talked about two of her projects, one in the United States and the second one based in West Africa. The first project addressed the legacies and aftermaths of the institution of slavery in the United States through the lens of historical trauma. Family groups that were the descendants of former enslaved people were invited to come together and start a conversation with the descendants of former slaveholders who were related to each other through the same farming plantation system. The project integrated history, healing, connecting, and action. Julia assumed multiple roles in the project including facilitating the conversations. She explained how the project helped groups of people to weave a collective narrative by noticing similarities across their experiences, identifying the overt and subtle behavioral patterns that got passed down across generations, and how these patterns played out in their families and communities.

> People could really explore what those collective experiences were. You know, how they both had experienced direct traumagenic experiences through their family, through their community, and they could start putting together the more subtle aspects of how their families, how their cultures were perpetuating [pause] their inability to really claim their whole selves.

Julia emphasized the importance of helping people to claim their whole selves, which was also true for those participants who identified themselves as descendants of enslavers.

> You know, within a lot of families, there was a huge emotional disconnect. So there is something about being enslavers that required one to disconnect, head-heart. People talked about that, that they were not close with their parents. They were not close with their families. And they felt like they needed to heal from that and to be able to access their hearts, to be able to access, you know, their, their full sense of being and capacities.

As a facilitator, Julia engaged in a lot of personal work before and during the project. Facilitators had to go through co-counseling training around racism and had to be part of a co-counseling group. She highlighted the importance that practitioners in this field do their own personal work before trying to support others through their issues. They should be able to understand what a safe space means for themselves and to come to terms with the impact of traumagenic systems and experiences in their own lives. "I think as a facilitator, a group is only willing to go as far as those who are holding the space are willing to go."

A key aspect of the project was establishing safety and building trust because of the sensitivity of the topics being discussed. Julia stated that "building relationships of trust" with individuals and families who were willing to come forward and have this conversation was critical to the success of the project. Safety and trust were facilitated by making sure that everyone knew that participation was completely voluntary and by "being very clear and transparent with people about what it is that we were coming together to do." It was also important to ease participants into the process by creating opportunities to get to know each other as human beings and hearing from other individuals who had built relationships with people from the other side of the racial construct.

Another essential component of the project was having facilitators with varied experiences and perspectives holding the space. Julia explained that it was also helpful to enlist the expertise of a historian to provide essential context to the conversation and shed light on those aspects of history that were never taught or discussed.

Julia then talked about her other ongoing project based in a West African country. The purpose of this community-owned and -led project is to support villages to heal and rebuild following a civil war that lasted for several years and later the outbreak of Ebola. Within the

different villages, the project facilitated individual and community healing through traditional practices, including include truth-telling bonfires and traditional cleansing ceremonies. The organization where Julia currently works partnered with a local non-profit, supporting the coordination and implementation of the project and training representatives at the district and chiefdom levels and facilitators working at the village level.

Julia believes that coming together as a community is important because people need each other to construct their own stories.

> Even though people's stories are individual, they're also collective. They hear each other's stories in each other. So as somebody is brave enough to speak what happened to them, it helps loosen other people's stories. It helps them face what happened to them as well.

Coming together as a community also imparted a sense of wholeness, helping people feel that they were part of something bigger than themselves. “If you're being held in a larger container, there is extra energy, motivation, [and] movement that helps you move forward in a way that you just couldn't have done on your own.”

The project drew in both the survivors and the perpetrators of the violence, some of whom were child soldiers who had been conscripted against their will. Julia stated that these community interventions helped people realize that what happened to them was neither personal nor their fault, that their story was part of a broader narrative that influenced people’s behaviors and actions. She explained that “whether we're talking about war, whether we're talking about colonialism or racism, it's this, it's a bigger pattern that people get engaged in. It's not just an interpersonal experience.”

Two important aspects of the project were the application of traditional ceremonies and the involvement of community leaders and various community representatives. Julia stressed the healing potential of traditional ceremonies and rituals that draw on ancient cultural traditions. These practices help instill a sense of pride in the community members. Additionally, community ownership was ascertained at all levels through initial consultations and community-led preparations. Julia highlighted the importance of making sure that the process is open, transparent and representative, and that everyone's voice is heard. The project team also worked closely with a diverse and representative group of district leaders, including chiefs, women leaders, religious leaders, youth, war survivors, and ex-combatants. Also, gender balance was ensured throughout the entire process. Eventually, the project led to the creation of separate groups for women to support one another, share experiences, and become more empowered to raise their voices in their communities.

Julia argued that trauma healing and community development are interrelated processes, although they are usually depicted as distinct activities that have to take place in a certain sequence. "And it's not just about trauma healing. … But it's also a collective process and discernment around how the community wants to develop moving forward." Sometimes communities decide to come together to address significant social issues, which prompts them to embark on their healing journey. "Okay, we have to face this. We have to heal because we want to move forward together." Julia also mentioned that an important step toward healing and rebuilding is being able to name the problem and identify collective priorities. "You have to name what's going on to be able to heal it. You have to identify it. And so for a community, to identify what those cracks are, is critical." Julia believes that the power and wisdom to heal, solve problems, and rebuild comes from within communities not from the outside.

Kevin

Kevin is a Canadian First Nations registered social worker and scholar who has over 30 years' experience doing community healing work in urban and reserve First Nations communities. His specializations are Indigenous mental health and substance use, fetal alcohol syndrome, suicide, community and youth engagement, and cultural safety. Kevin currently works in the area of Aboriginal engagement and outreach at a mental health, teaching, and research facility that serves communities in Southern Canada, providing a wide range of clinical care programs and services. He has a master's degree in Indigenous community development and education. Kevin is also very active in social justice advocacy and public education on the tragic impacts of the Canadian residential school system and colonialism at large on the mental health and livelihoods of Indigenous peoples, and the reconciliation of colonial injustices. Additionally, Kevin continues to contribute to the literature on Indigenous issues as an author.

Kevin talked at length about the repercussions of the colonial legacy in Indigenous communities across Canada, particularly in remote communities in the North, where some people "live in third world conditions." He explained that his perspective and social work practice have changed dramatically over the course of his career as he began to understand the historical and systemic backdrop to the slew of hardships faced by Indigenous families and communities.

> Like a lot of indigenous people, from generation to generation, we're just trying to survive and we don't really understand the hostility and how people ... Again, the negative stereotypes, everything, we don't really understand why. Why is that? So we internalize that. So I think it impacted the way I practice.

Kevin argued that many Indigenous people are oblivious as to why their life situation and the social conditions around them are so dire, as if they are still in shock, which for Kevin is the most accurate definition of trauma. "That's trauma to me, people who never knew what hit them. That's a better description of trauma to me."

Kevin sees Indigenous peoples and people of color as being on a "melancholic journey of self-discovery" that paves the way to personal and communal transformations. He thus perceives his role as a witness, accompanying individuals and communities through their journey to reclaim their human dignity, find their own voice, and recover the protective cultural elements that were lost in the wake of colonization. Another focus of Kevin's work is helping families mitigate the intergenerational transmission of trauma by limiting the exposure of youth to adverse childhood experiences, which undermine the development of resilience.

Kevin reported that over the years, he has become skeptical of the prevailing conceptualizations of psychological trauma. He wrestles with the concept of trauma and how it has been applied in Indigenous populations, oftentimes weaponized against historically disenfranchised groups by validating that there is something inherently wrong with them. He explained that traditional conceptualizations of trauma overlook the political aspect of the challenges and obstacles influencing Indigenous people's health and well-being. He advocates a "wholistic" understanding of trauma that takes into account the mental, the social, and the political.

Additionally, Kevin argued that trauma commonly serves "like a blanket over atrocities. We never spend enough time on the resilience and the people that actually muddle through and become leaders, who become activists." In his work, Kevin tries to dispel the notion that Indigenous people need to be fixed and instead tries to uplift their resilience. "I spend a lot more

time with people talking about dependable strengths and what are the things that are going to keep you moving, the whole positive psychology." Kevin also does a considerable amount of psychoeducation as part of his work in communities, helping people make sense of their experiences and struggles within Canada's colonial context. He stated that he likes the rational component of rational emotive behavior therapy (REBT) because it gives him "the space to give people a context to what is around them, and what they are experiencing." Kevin tries to adapt Western therapies like CBT to accommodate Indigenous understandings and worldview.

Kevin believes that a society can only be judged by the way it treats "les miserables." He feels disillusioned by systems and institutions grounded in a WEIRD (Western, educated, industrialized, rich, and democratic) belief system, which continue to dehumanize and perpetuate harms against Indigenous peoples. He noted that these institutions are by and large run by people who are removed from the historical and cultural reality of Indigenous populations in Canada. In his work, Kevin meets survivors of residential schools who have been re-traumatized by the legal system because of the poignant disclosures they had to make to claim for reparations compensation. He explained that survivors are offered no support from counselors or therapists to fill out these applications.

Kevin was similarly critical of mental health services, particularly because fixing Indigenous people has become a "big business" in Canada. Furthermore, behavioral health programs are typically run and manned by individuals who are out of touch with the impact of colonization on Indigenous people, and are therefore unequipped to provide adequate support to Indigenous clients. He drew attention to the necessity for cultural safety in these healing spaces.

> It upsets me that people ... generally, the people that make the assessments or the people who diagnose people [are] the people who benefited from or were part of, or were

bystanders, or never recognized where that all came from, are the ones that basically control the health services or helping people beyond those impacts.

Kevin emphasized the need to train future generations of therapists, including Indigenous counselors, in cultural safety and decolonizing trauma and healing interventions. He also underscored the need for adequate support to front line service providers in remote communities. Additionally, Kevin pointed to the difficulty of devoting sufficient time and energy addressing historical trauma when a considerable amount of effort is taken up by incident- and crisis-focused demands.

Maya

Maya is an Asian American social entrepreneur and community mental health facilitator and educator who runs a non-profit in San Francisco, California, that works toward breaking generational cycles of trauma and harm through community education, healing interventions, and activism. Her work is positioned at the intersection of healing and justice, and through her organization she seeks to promote individual and community healing and resilience and to democratize access to healing resources. Her organization supports communities in the United States and abroad. Maya has close to ten years' experience working in the field of trauma healing and resilience. She has received formal training in trauma-informed interventions and global mental health.

At her organization, Maya facilitates trauma healing circles for community members who are grappling with the impacts of historical trauma. The majority of the attendees participating in these healing circles identify as African Americans. Maya believes that healing from the legacy effects of historical trauma is best achieved in a group setting.

> Because historical trauma is, is collective, it's like that relational healing process is so important. And while I think there is a need for one-on-one healing tools, the biggest opportunity for healing historical trauma is when we do it together in a circle.

Her organization also partners with other non-profit organizations that are already serving their community. Maya facilitates workshops to build the skills and capacity of local leaders, including educators and front-line workers supporting sex trafficking survivors, survivors of sexual violence, and young men impacted by street violence, to serve as peer counselors and healing activists in their communities. Maya stated that many of the community leaders who attend these workshops "do not have any kind of licensed mental health background, even though they are doing incredible work." She explained that some local leaders may not have access to formal mental health education because of historical oppression.

In these workshops, Maya offers basic psychoeducation about trauma, including what trauma is, its effects, and the physical, mental, emotional, social, and spiritual impacts of trauma. She tries to emphasize the physical, social, and spiritual dimensions of trauma because she feels that these aspects are often overlooked by the dominant approaches to mental health. Maya also provides workshop attendees with tools that they can use to support trauma survivors during crisis situations and over the long-term, such as basic helping skills and emotional first aid. Other techniques that she uses are grounded in somatic-based, mindfulness-based, and cultural and expressive arts-based modalities. Maya believes that it is crucial that people understand how their body reacts to traumatic events and memories, how to calm down their body's physiological response, and how to regulate their nervous system. All her workshops are experiential because she wants participants to experience the techniques as opposed to only understanding them cognitively. She added, "And our hope is that they have their own

experience of healing within the workshops as well, so that there's these parallel processes that are happening."

Another component of her work is to help individuals reframe trauma by re-directing their focus on the strengths, resilience and wisdom that they possess. Maya believes that it is not enough to retell your story; it is important to reframe traumatic experiences from the perspective of strengths and courage. She also emphasized the importance of celebrating one's indigenous roots and cultural practices, and of acknowledging the wisdom and resilience that is embedded within one's culture.

One of the overarching goals of Maya's work is to de-stigmatize and de-pathologize trauma to encourage individuals, communities, and organizations to embrace healing as a universal responsibility. "To normalize it, to normalize both that every human experiences it, and also what the responses in, you know, in our brains and bodies. Like, it is totally normal when your brain goes into fight, flight, and freeze." She criticized mainstream mental health models, stating that they are mostly White Western-based and tend to be "too clinical, too medical, too pathologizing… and not really fitting within the cultural context that they're doing the work."

Another facet of Maya's work is to help trauma survivors and community leaders understand how unhealed trauma is linked to cycles of harm and that healing should not be relegated to survivors; even aggressors are responsible for healing their trauma.

> Like, "This is something that happens as a result of trauma." So, you know, we don't need to, to blame, but we do want to hold ourselves and others accountable. We are all accountable for both examining our own acting out and acting in responses and, you know, where we can make the change.

She is currently collaborating with another community organization to develop an eight-week program that will invite trauma survivors and perpetrators to work on their healing side by side. Through her work, Maya wants to expose how healing at the individual level is connected to healing at the family and community levels. She also wants people to realize how violence has become so normalized that people, systems, and institutions often respond to violence with further violence.

Maya believes that healing has to happen from the inside-out rather than from the outside-in. She explained that institutions are made of people who unconsciously are reacting to their own fear through enacting violent and unjust policies. She believes that institutional changes are unsustainable in the long haul unless the people who make up those institutions have done their personal healing work.

> "Even if like we're lucky enough to be in a time… where we might have, you know, a greater appetite and awareness, and care for the most vulnerable, then [chuckles] without that individual healing, it will just flip flop to the other side once the other, once, you know, another party gets in place in our system."

Maya mentioned two challenges associated with her work. The first challenge is funding. She explained that it is already hard to gain access to funding for mental health initiatives. She argued that the challenge is even greater for mental health work that tends to be perceived as radical because it does not fit in the dominant medical model and its impact cannot be assessed using traditional methods of evaluation. "Part of it is because also the impact is longitudinal. No one, no funder likes to wait more than a year to get their reports."

She also expressed concerns around how to continue offering support to the community leaders who attend the workshops and may then go back to their communities and feel isolated.

"I feel really motivated to try to find something because that isolation makes this work so much harder, and the whole point of this work [emphasis] is that we heal in a community." Over the years, she has tried to generate formal and sustainable ways to check-in with workshop attendees and monitor "the ripple effect impact" of her work.

Maya emphasized the importance of attending to her own healing as an integral aspect of her work in communities. She explained that personal healing has to be an ongoing commitment because it is intimately connected to the work that a practitioner is doing. "And in that way, we're really just kind of mirrors that are reflecting each other's and our own healing."

Nathalie

Nathalie is an American community interventionist, scholar, and educator who has a Native American and European heritage. She has over 40 years' experience working with countless communities in the United States and Canada, especially Indigenous communities. She currently works at the Middleton-Moz Institute (permission to name the organization was granted by the participant). As part of her work at the Middleton-Moz Institute, Nathalie teaches in a graduate social work program that focuses on indigenous trauma and resiliency. She is responsible for preparing future generations of trauma-informed social workers who are equipped to work with individuals, families, and communities affected by historical and generational trauma using culturally appropriate approaches that draw on traditional wisdom and practice and cutting-edge scientific knowledge. Nathalie has a master's degree in clinical psychology and is a licensed psychologist. She has served in various capacities in several community agencies and non-profits. Nathalie continues to contribute to the literature in the areas of trauma, grief, and anger.

Nathalie's interest in community interventions grew out of her involvement in a community-based program for prisoners while working as a clinical director at a mental health center in Northwest United States. At the time she realized that "one of the biggest issues is that we're not working with whole communities," which inspired her to develop a model for community-wide interventions. Over time she grew more skeptical of one-on-one clinical treatments that tend to decontextualize people from the rest of their social world, and hence conflict with collectivistic worldviews and values. She explained that, "We're not looking at people in the context of their life and their, their family system for generations." She also became more conscious of the existing pitfalls in the current mental health system, including the overreliance on the DSM, which leads to the over-diagnosing of individuals, and the growing influence of the pharmaceutical industry on mental health. She believes that trauma is oftentimes pathologized, and as a result people are being diagnosed as sick when in fact they are having a normal response to harrowing life experiences. In her community interventions, Nathalie helps people understand that "they're having a normal response to an abnormal and painful life, and that they have tremendous resiliency." Maladaptive behaviors are conceptualized through the lens of survival. She also helps people understand the source and triggers of maladaptive behavior, such as domestic violence.

Nathalie reported that the primary objective of every community intervention is to enable families and communities to redevelop the attachment and connection that were disrupted by the trauma. Nathalie argued that most of the anger, rage, and lateral violence that are exhibited in communities proceed from disconnection and an underlying sense of powerlessness and vulnerability. She noted that "connection is correction." By restoring connection and

communication, the community is able to rehabilitate and reconstitute its culture. At the heart of rebuilding connection is validation.

> The second [objective] is to be validated for what happened to you and that it was not you. We call it regaining your human beingness. That you're not a diagnosis, that you're not crazy, that this is something that happened, and this is what you did to protect yourself, which is part of your resiliency.

Additionally, interventions are designed to build the communities' capacity to navigate future challenges and continue moving forward in their healing trajectory.

Nathalie stated that it is important to work with both the adults and the youth when working with communities. When her team gets invited to intervene in a community to help its members address a particular problem, such as suicide or domestic violence, she follows a number of steps to ensure safety and the sustainability of the intervention. Nathalie explained that the first thing she does before going into a community is to carry out the necessary groundwork. During this phase, she gathers information about the community, such as expectations, strengths, significant positive and adverse events during the past year, what the community identifies as success, and how people celebrate. Next, the community organizers identify those people whom they feel are really important to join the intervention. A fundamental requirement in this phase is that the organizers enlist a group of people from that community to work on the intervention team. Nathalie explained that she will not go into a community unless she has a group of community members on her team. She believes that having community members join the intervention team improves the sustainability of the work that she is trying to accomplish.

> But whenever we go into a community, we ensure that members of that community are on our team. So they are learning from us as we're doing it, so that when we leave, we leave the skills. And we leave the support with the community when we leave.

The actual community intervention is about six days long. There is usually a team that works with the youth and a team that works with the adults. The elders from that community are represented in both groups. Nathalie also provides space for men and women to work separately on their issues, but the entire community always comes together at the end of each day. Safety is addressed first, and then the focus shifts to emotions, which is followed by empowerment. When the community gets to the empowerment stage, the team turns it over to the community to organize ceremonies. Nathalie reported that ceremony is an important component of all community interventions.

> One of the things we built into the work is making sure that at the end of the entire intervention, I have the men develop a ceremony for the women, to honor the women. I get the women to develop a ceremony to honor the men. And then I have both men and women to do a ceremony to honor the youth.

Nathalie claimed that one of the most powerful moments during an intervention is when members from the different community groups, such as the adults or the men, begin to recognize how their own trauma has been a source of deep anguish for fellow community members, such as the women or the youth, and apologize for their behavior. She explained that the renewed awareness makes it possible for everyone's suffering to be validated, which helps to heal relationships and bring the community closer together.

A major consideration when working with communities is that the interventions are culturally appropriate and honor each person's diversity. Nathalie claimed that the interventions

are based on “the values of kindness, respect, inclusion, and belonging.” She is also mindful of what language the community members use to express themselves. She explained that “it's important for people to grieve in their own language and also to be able to speak that in their own language.” Nathalie is also adamant about keeping the community’s needs at the forefront, and she therefore tries to have a flexible agenda that can be easily modified depending on the community’s circumstances. All interventions are participant-driven, and Nathalie’s team is trained to follow the lead of the community and not vice-versa.

Nathalie uses several tools to facilitate the interventions. One of these techniques is community mapping, whereby the community identifies which settings in the community are safe and unsafe, as well as any historical events that had a significant impact on the community. She also uses trauma-resiliency life lines, color-coded genograms, and community trauma lines. Nathalie integrates psychodrama, tactile activities, music, and dance in her interventions to help people construct their personal and community narrative. One example is using beads to create a bracelet or necklace that represents one’s life.

A central component of every intervention is daily debriefings of the intervention team. In some cases, Nathalie first works with the mental health professionals serving in that community before delivering the actual intervention with the community members. The goal of phased interventions is to train mental health professionals on how they can intervene differently in communities and help them work through their personal challenges.

Nathalie emphasized the necessity of doing the needed personal work as a mental health practitioner. She believes that if mental health professionals “haven't worked through [their] own stuff, [they’re] not able to build that attachment.” As an educator, she helps students develop a wellness plan that she reviews with them every three months. Nathalie criticized some

of the rigidity that prevails among mental health professionals, which oftentimes limits how they connect with the people and the community with which they are working. Nathalie explained that practitioners have to adapt their modus operandi when working in different cultures; this conviction galvanized her resolve to join academia and develop a program that educates social workers differently.

Pablo

Pablo is a White American psychiatrist and psychoanalyst who has over 40 years of experience in facilitating dialogue between representatives of rival groups or factions. Pablo has worked in many countries including the United States, but most of his work is internationally focused. He applies psychoanalytic theory to understanding large-group processes and his interventions focus on large-group identity. Pablo recounted how he was introduced to this field through the American Psychiatric Association, which led him to become involved in bringing together influential Arab and Israeli representatives for unofficial negotiations. He later established a center that included an interdisciplinary team of experts who travelled to various regions around the world that were caught up in a political conflict. Pablo worked extensively in the Baltic region after the collapse of the Soviet Union.

Pablo defines historical trauma as the generational transmission of shared responses, images, and losses following a shared traumatic event experienced by a group or culture. He explained that shared traumas become entwined in a group's large-group identity and serve like an identity marker. Pablo argued that understanding large-group identity is extremely important in understanding how groups become embroiled in endless political conflicts. He likens large-group identity to a tent that subsumes all the people that ascribe to that identity. He explained that the tent has many signs and markers that define what it is and what it is not. If the tent gets

torn in some place, that is if a group humiliates the large-group identity of another group, the aggrieved party harkens back to its shared trauma marker. This revisiting of old wounds is a regression of sorts that can fuel retaliation and lead to conflict escalation. Pablo stated that "people kill in the name of large-group identity." He claimed that large-group identity takes precedence over individual identity whenever one's large-group identity is threatened. He further argued that chronic, unresolved conflicts are often contaminated by psychological resistances.

Pablo provided several examples of his work. Whenever he was invited to intervene in a country or region, he always adopted a medical approach by first making a diagnosis. He typically spent from six months to a year interviewing different people, mostly civilians, to investigate and find out what was going on in that country or region. Next he identified and selected 12 to 16 representatives from each side, usually people who held some influence in their respective country, and invited them to the table for talks. Pablo emphasized that his role in the discussions was always that of a psychoanalyst and not a diplomat.

> When we brought enemy representatives together [pause], I was not a diplomat… All I knew was I don't tell you what to do. I listen to you, I help you to find out solutions and so on. So when we had the meetings, people would wait for me to ask questions or do this or that, and I acted automatically like a psychoanalyst.

He explained that he or another psychoanalyst would facilitate the talks for the first three days and on the last day, he would hand over the facilitation to a diplomat to discuss how the respective parties wanted to proceed.

During the talks, Pablo helped the representatives of each party explore and gain insight into their respective chosen trauma, and to become aware of how these deep-seated traumas

might be influencing present-day attitudes and behaviors. Pablo explained that functioning from one's chosen trauma generates a time collapse, whereby the past and the present become enmeshed. Pablo's interventions were aimed to help representative parties experience a "time expansion for them to have realistic discussions." The overarching goal of Pablo's interventions was to facilitate peaceful solutions and avoid bloodshed.

When talking about his work, Pablo emphasized three principles that need to be observed when facilitating dialogue between opposing parties. The first principle is to remove any threats to the large group identity of the respective conflictual groups participating in the talks. "So we developed the idea that when we bring people together, keep a psychological border, so they can keep their identity secured, they can make more realistic discussions. You don't have to be lovey-dovey in order to make conversation." The other two considerations are avoiding unnecessary attention by the media that could endanger the safety of the representatives engaged in the talks, and maintaining transparency with top government officials at all times. Because no single discipline can independently illuminate the complexities of the work, Pablo always worked within an interdisciplinary team. His team included experts in many disciplines including psychoanalysis, psychiatry, diplomacy, political science, history, linguistics, law, and environmental policy. Pablo emphasized the need to fund more psychological research in this field.

Renata

Renata is an Asian American social entrepreneur, community mental health facilitator and educator, leadership and organizational consultant, and activist who currently runs a non-profit in San Francisco, California. She delivers leadership programs designed to promote emotional health and build resilience among service-oriented community leaders, most of whom

support individuals affected by the present-day impacts of historical trauma, such as domestic violence and gentrification. Through her organization, she also provides consultation to other civil societies that are working toward peace and social justice. She has 11 years' experience working in the field of trauma healing, emotional health, and resilience both in the United States and abroad. Renata has a master's degree in social work and public health. Having practiced in the past as a social worker and as a global health practitioner, she has witnessed first-hand the impact of burnout and vicarious traumatization of practitioners working on the front line.

Renata talked about her work in the United States, Central America, and East Africa. In both Central America and East Africa, she worked closely with local organizations that already had a relationship with the targeted communities. Although every intervention had a different focus, Renata highlighted common elements across the projects. She emphasized the importance of listening to the community and making sure that the intervention meets the needs of the community. Additionally, it is important that the process is led by the community. While working in a country in Central America, the community leaders requested help to exhume the remains of loved ones who had been buried in mass graves during the genocide so that families could properly bury their loved ones. As a result, the project team ended up enlisting the support of legal and forensic experts. Although the project took an unexpected turn and completely moved away from what Renata and other team members had envisioned, she explained that it was more important to honor the community's terms of how they wanted to heal. "Originally I was thinking, 'Oh, we'll do groups, we'll do women's groups and youth groups.' But that wasn't what people needed or wanted and, and I wasn't a part of that community." Renata stressed the importance of staying open and humble, and trusting the wisdom of the community.

Another fundamental aspect when working in communities affected by historical trauma is being aware of one's cultural identity, including what one's identity represents to the people one is serving, and how that can impact trust-building with the community. Building a trusting alliance with the community is another central component. Renata stated that enough time must be allocated for preparation and building trust with the community.

Over time, Renata began to realize that uplifting the resilience and wisdom of the community was equally important as trauma healing. She highlighted the importance of participating in the cultural ceremonies and healing rituals as a way to acknowledge and validate that resilience. Referring to her work in Rwanda with youth with HIV, she explained how impressed she was by the youth's enthusiasm and capability to lead a community-wide process and to rally the support of authority figures in their community. One of the challenges that she encountered while coordinating youth groups in Rwanda was funding. Renata explained that short funding cycles limit what can be achieved through the intervention. She highlighted the importance of adjusting the plans around the funding early on in the project. Renata also drew attention to the irony in the situation; while funding cycles are typically short-term, healing generational trauma entails longer-term interventions.

Renata emphasized the importance of group interventions as opposed to one-on-one when talking about the healing circles organized at her non-profit. Racial trauma and the repercussions of gentrification come up often in her work and the circles offer a safe space to have difficult conversations about sensitive topics. Renata argued that shame and stigma are better addressed in a group setting. She also criticized the inaccessibility of traditional mental health services to people of color and their lack of cultural competence.

> So if, if I'm someone who, I'm a person of color, I've been displaced, I want to seek mental health support, very often that will be in an institution that's unreachable to me or it's hard to find another person of color as a practitioner.

Renata emphasized the importance of self-care and working through your own personal trauma as part of doing this work.

> Because I really believe that our own process of healing is really connected to the work that we do. And when I have to face my own difficulties and, and life traumas, that makes me a better practitioner because I'm able to be on the other side and realize "Ooh, this is hard work."

Simone

Simone is a White Canadian registered counselor and clinical supervisor with over 10 years' experience in the fields of counseling and psychotherapy. She has a master's degree in creative arts therapies and is a registered art therapist. She is currently working on her doctoral degree. Simone runs a private practice and teaches graduate courses in counseling and art therapy at an academic institution. She first came across historical trauma early in her career while working with immigrant and refugee children from war-torn countries. She later started working with Indigenous populations in Northeast Canada.

Simone highlighted the complicated nature of historical trauma. Historical trauma creates a psychological rupture that sends shock waves that are felt across multiple generations. She talked about the lasting impacts of the residential school system, the intentional annihilation of cultural practices, and the ongoing systemic racism on Indigenous communities, including addictions, PTSD-like symptoms, domestic violence and sexual abuse, poverty, homelessness, and challenges to holding steady employment. Simone also drew attention to the high incidence

of relational trauma as well as the difficulty in establishing and maintaining long-term trusting relationships.

Simone works with children, youth, and families in Indigenous communities. She uses creative art therapies to work with this client population, including art, play, and sand tray therapy. Simone reported that these modalities tend to be quite effective with Indigenous children and families. She also tries to integrate somatic experiencing trauma therapy and spirituality in her practice. Simone noted that addressing spirituality is extremely important when working in Indigenous communities. She explained how over time she started to follow her clients' lead and increasingly incorporate language around the spirit in her interventions.

> It is respecting the roots of the people. I think also for the work to be effective there has to, the person has to fully be able to come into the room… It's not just their body. There's their soul, their psyche. Everything must be accounted for.

Most of her clinical work in Indigenous communities revolves around grounding, establishing safety, and harm reduction. Simone explained that some of the people she works with have never known safety in their lives. An important aspect of establishing safety is broaching with clients about her cultural identity right at the beginning of her therapeutic relationship and giving them permission to talk about their experiences of racism and the history of their community.

> And I'm also, again, really conscious of the fact that I could for them represent all sorts of things, right? Because of my social identity and white skin, and all that. And so I try to name it in a light way, but I do, I mean, right from the outset. And, you know, I'm also trying to give permission that, you know, if this doesn't feel okay, let's figure something for you that does.

Simone explained that she wants the clients to know that she is standing in solidarity with them. She also noted that "maybe there's a healing for me too, to be able to say, 'Yeah, this is going on and this really sucks. And I'm sorry that this is happening.'" Simone perceives doing no harm and making sure not to recapitulate the damaging relational dynamics proceeding from colonialism in her relationship with clients as her main priorities in her work. She also talked about the importance of being able to sit with the discomfort of being perceived as part of the perpetrating group because of her whiteness.

Encouragement is another important piece. In her work, she encourages clients to identify options and alternatives to managing their pain differently, "in a way that they're not harming themselves or putting their safety or their kids' safety at risk." Simone also encourages clients to turn to helpful cultural practices, resources, and supports that already exist within the culture and community. She explained that "there is actually a lot of health and wellness and healing in Indigenous communities. So it's actually not that hard to kind of just refocus, re-shift a little bit." When intervening with children, with their permission and consent, she reaches out to and collaborates with the people who are part of the child's social system, such as parents, grandparents, their teacher, and their social worker, to create a strong support team around the child.

As part of her work, Simone regularly checks in with the chief, elders, and people who are in a position of power in the community to come up with appropriate and culturally respectful ways to work within that community, and to seek their perspective on where they see her work going and how she could do things differently to better support the community. Simone has also joined healing circles in the past, where community members discuss a particular issue such as a death in the community, or a conflict between two or more individuals

and families, or a child being taken out of parental care. She compared the process to group therapy but having deep Indigenous roots. When participating in healing circles, one of her priorities is to hold as much safety as she can for the community members. Simone explained that when invited to join a healing circle she is constantly mindful of the fact that she is entering a cultural space that does not belong to her, so she approaches the task with humility and respect, following the lead of those in charge of the process. She has also participated in potlaches and other traditional ceremonies. Simone also tries to make herself available to the community for casual conversation, which she described as "a therapeutic way of offering, which is culturally respectful, but just offering a less formal, I guess, mode of support."

Additionally, Simone provides support and clinical supervision to other counselors and therapists working in remote rural areas using teleconferencing technologies. Based on her own experiences as a therapist, she is keenly aware of the significant impacts that the work can have on mental health providers and their families, such as secondary traumatization, burnout, and relationship problems. Oftentimes, these challenges drive practitioners working on the frontline to leave the field or the community, which results in a high turnover of community service providers.

> So, you get a lot of turnover in terms of the helpers that are there. And then communities are like, "Oh yeah, how long are you going to stay? What, are you here for six months?" That kind of thing, you know, a little bit of a jadedness.

Simone believes that clinical supervision and self-care are core to the sustainability of the work. She tries to emphasize the importance of self-care with students who are training to become counselors and psychotherapists.

Simone believes there should be more funding that gives people in Indigenous communities greater access to mental health services and resources. She also highlighted the need for community building that is respectful of the communities' needs and wishes and led by the communities themselves.

Wendy

Wendy is a Canadian First Nations scholar, practitioner, and educator who currently works in an academic institution, leading truth and reconciliation initiatives in response to the calls for action articulated by Canada's Truth and Reconciliation Commission. As part of her academic position, Wendy does community engagement and reconciliation work in communities across Canada and conducts public education sessions on a regular basis. Wendy has over 35 years of experience working with Indigenous communities in Canada and most of her community work and scholarship revolves around the intergenerational transmission of trauma and grief in Indigenous populations in Canada. She has done extensive work with youth and is deeply committed to active youth engagement. She is also a faculty member at another educational institution where she teaches on a number of Indigenous leadership programs. Wendy has served on several advisory boards related to Indigenous mental health and has contributed to reforms in the Indigenous child and family welfare system. Wendy has a doctoral degree in cultural anthropology; however, she has mostly taught social work, Indigenous studies, and history.

When Wendy started working in Indigenous communities in Canada she was primarily involved in land claims and treaties, but over time she realized that it was impossible for communities to effectively address self-governance matters without dealing with the legacy effects of historical trauma, including high levels of addictions, depression, domestic violence,

and sexual abuse. In her community work, Wendy supports community members to voice their challenges. She also helps people make sense of what they are feeling and experiencing in their families and communities by framing contemporary challenges within the history of the community and by calling attention to subjects like adverse childhood experiences and epigenetics. “People are now finally getting to the place where they're starting to understand that, that it's not about what's wrong with you, but what happened to you, you know, or what happened to your grandparents.” She argued that mental health professionals need to be cognizant of the historic past of the community in which they are working. Wendy also helps people understand that historical trauma is manifested in how people behave around each other, which becomes part of the culture of a place. “If everybody you look at is high on something, then, you know, what is that? That is the culture [chuckles]. You know, it may not be what you want it to be, but it is what it is.” Wendy stated that when people start understanding themselves and their situation better, they are more inclined to take action to improve their life situation and that of their community.

A central component of Wendy’s work is mobilizing people and communities to take action. She encourages people to look around them and decide which aspects of their life and their culture they want to keep, and which aspects they want to change. She helps people recognize that they have options, that they can change their course.

> We ask people to look at, "What's happening around you right now?" "What do you want to keep and what do you want to change?" You know, "What do you, when you move forward in your, in your life or your community's life, what should be there?

Wendy emphasized the importance of listening to the community members and asking them what they want. She criticized mental health professionals and other service providers who go into Indigenous communities and assume that they have the answers.

> Because lots of times they send people into our communities who are not from the community, and they're in there, you know, telling us, "Oh, this is how you help yourself. This is what you need to do." And, you know, and they're not listening at all [emphasis]. They're not understanding that these people just need somebody to facilitate their conversation. Let them have their conversation. And you're not there to tell them what to do.

Wendy also encourages community members to shift their attention to people and elements in their social surroundings that are uplifting and promote resilience. She explained that although there are events and circumstances that can "send you reeling," there are experiences that can lead people towards their healing. "The bottom line is, you know, get yourself around good people. You know, go to a place where people are uplifting. Get on the pathway that leads you to healing." In her work, she draws on Indigenous knowledge, such as the seven teachings, and integrates rituals and ceremonies. She encourages people to get involved in these cultural healing practices or other preferred cultural practices. Wendy also stressed the importance of adapting Western approaches to accommodate Indigenous values and worldview.

Besides working in communities, Wendy is involved in educating non-Indigenous people whose occupation requires developing rapport with Indigenous communities. She helps prepare teachers before they go into remote communities so that they have an understanding of the impacts of the residential school system and other historical harms on the children they will be

teaching. Wendy also trains conservation officers. She explained that although her work is focused on Indigenous peoples, she tries to engage people from other cultures in the conversation by making the content relevant to everyone.

> Like, I tell these guys [conservation officers], "Ninety-seven percent of the population on this planet has had some form of trauma, and the other three percent are lying." [chuckles] Everybody, right? So I draw them in that way. … And I just talk to them about their, their experiences, their feelings, their, you know, knowledge of what hurt means. And then we talk about this, you know, "What are you seeing when you go into an Indigenous community?

Another strategy that Wendy uses to facilitate dialogue between people from diverse backgrounds is inviting them to map their genealogical story or to talk about their creation stories. She believes that being aware of one's ancestral roots is important and relevant for everyone. Likewise, creation stories are ubiquitous yet unique to the person's culture of origin. Wendy noted that one of her challenges when working with non-Indigenous people is unpacking the prejudices and biases that people walk in the room with and drawing them into the conversation.

> And that is the biggest challenge, is to have them wanting to hear what you have to say. I want to see them shed tears. I want to see them laugh out loud. … And go away and say to their brother, "I get you now."

Additionally, Wendy works with the federal government. She explained that having these multiple perspectives, as someone living in an Indigenous community and working with top officials in the federal government on Indigenous affairs, makes her work more enriching and to some extent easier.

Wendy also talked about the importance of being authentic when working with Indigenous communities. Although she acknowledges that self-disclosure has to be intentional, she believes that "when you go out into a community to work with the community, you have to bring yourself along."

Zora

Zora is a Black South African registered social worker, academic, and researcher. She has practiced social work in South Africa and abroad for over 15 years. Her expertise is in trauma, intergenerational trauma, gender-based violence, gang violence, and decolonization in the social work profession. She currently teaches in a graduate social work program while working in communities across Cape Town. Zora has a master's degree in play therapy and has extensive experience working with children, youth, and families. She started examining more closely historical trauma while reading for her doctoral degree in social work, although she has always been interested in the subject on account of her personal experiences as a Black woman in South Africa and having grown up in the apartheid era. Her interest prompted her to reflect on the social conditions impacting the mental health and social well-being of Black communities in Cape Town, despite that the apartheid laws and policies had long been rescinded. Zora was also becoming weary of witnessing how Black families were being pathologized by mental health scholars, which often resulted in blaming individuals and families for the hardships that they were facing.

Zora conceptualizes historical trauma in South Africa, and especially in Cape Town, as resting on a continuum that dates back to the slave trade, when slave ships heading to the Americas would stop in Cape Town, which back then served as a refreshing station to stock up on food and offload dead and sick slaves. Racial and gender hierarchy were introduced in South

Africa during this juncture in history. She explained that this part of history has remained relatively obscure in the public consciousness of Black South Africans and most scholars in the mental health field tend to focus their attention on the apartheid and its legacy. Zora talked about the various challenges affecting Black families and communities including identity and self-esteem problems, stark social inequalities in wealth and income, educational success, and health, as well as the inexorable street and gang violence.

Zora described her work as being grounded in narrative therapies. She guides people to reconstruct their personal and collective narrative by connecting the past with the present. As part of her work, Zora tries to draw attention to the slavery narratives pertaining to Cape Town and to weave these narratives into the broader history of the region. She facilitates these conversations by using history maps and collective timelines. Zora also helps people become aware of how these multi-generationally accrued traumas feed into present-day social conditions and challenges. Another aspect of Zora's work is de-pathologizing trauma by encouraging people to reframe trauma symptoms as a natural response to overwhelming and stressful situations. She argued that the bulk of extant literature on trauma has been written from a Western perspective. Zora also tries to promote a strengths- and resilience-based understanding of trauma. In her work, she often highlights the contributions of enslaved people to the development of Cape Town apart from acknowledging the traumatic aspects of that history. "What's been written, the discourse around slavery tends to be either, you know, it's very traumatic or we're in denial about it." Zora explained that her narrative work around slavery, colonialism, and historical trauma helps to create new positions with respect to understanding oneself and one's social context and responding to the legacy effects of historical trauma.

Zora stated that she is rarely invited to deliver an intervention that specifically addresses historical trauma. She explained that most social workers and social welfare organizations are usually caught up in crisis situations. Over time, Zora learnt how to integrate her work in this area into other interventions that target present-day issues, such as gender-based violence, gang violence, and racism. An example is her work with the Government of South Africa on gang violence. She talks about historical trauma as part of the training with police officers. Zora has done this work with youth, women, religious groups, community organizations, and social workers. She recently partnered with a local museum, and in collaboration with the curators, she started delivering programs that raise awareness about the slavery heritage of Cape Town while including her work on historical trauma.

Zora talked about her personal work and coming to terms with her own heritage as another important aspect of her professional work in this field. She emphasized the importance of remaining authentic and acknowledging that she is affected by the work. Zora is committed to continue training social workers and other mental health professionals about historical trauma and has plans to develop a postgraduate diploma in trauma that covers collective and historical trauma in more depth.

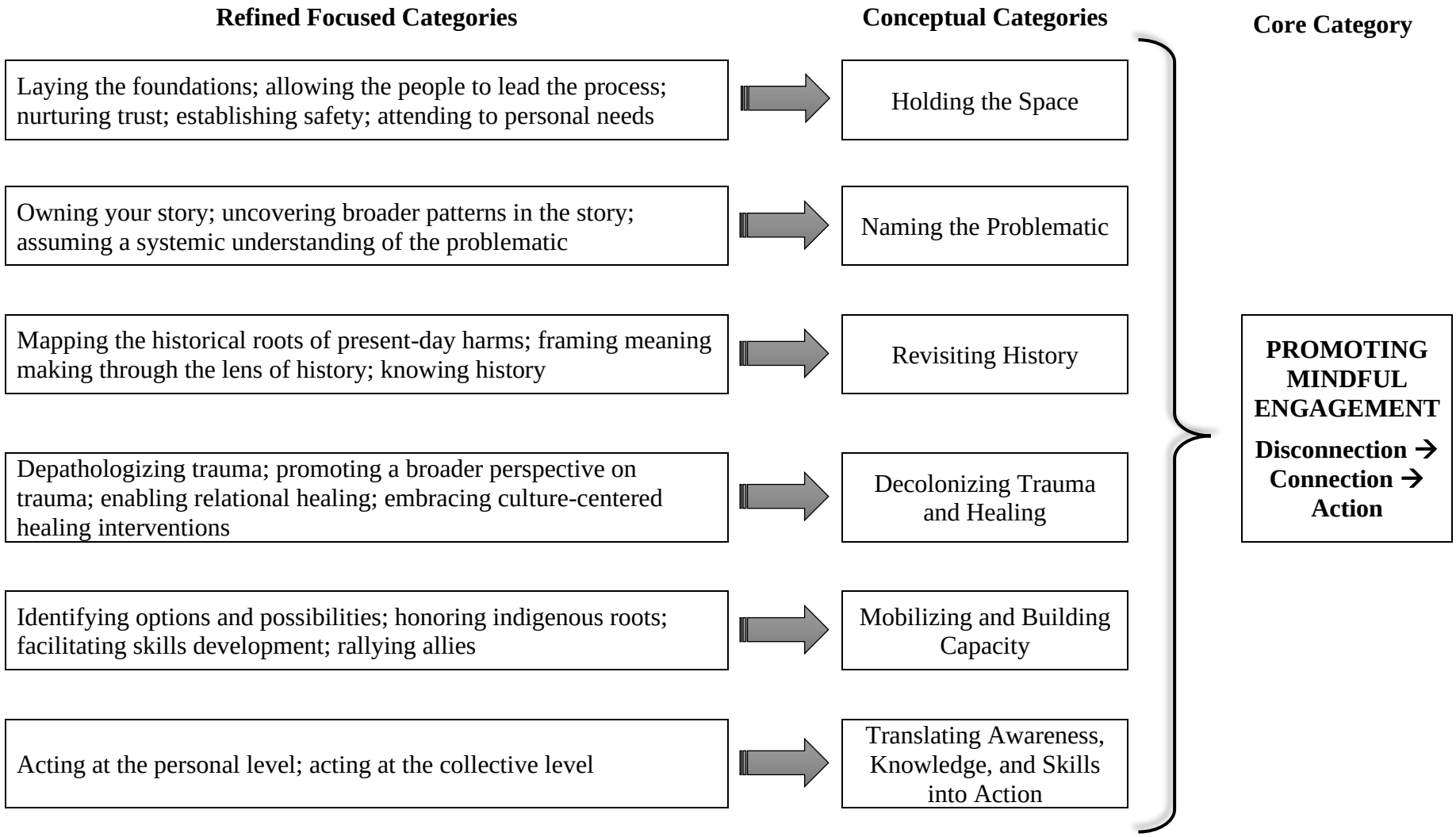
In this section, I provided a wholistic picture of all the study participants and how they address the phenomenon of historical trauma via their interventions in communities and at the society-level. The profiles are intended to provide the readers with the relevant background before I discuss how I went about fracturing and reconstructing the information provided by the participants and present my interpretations of the data and the findings of the study in the next section.

Theory Development

As explained in Chapter 3, data analysis and theory development were in progress from the time of my first initial interview and continued through transcription, initial and focused coding, focused interviewing, and finally theoretical coding. Throughout the integrated data collection and analysis process, memo-writing and comparative methods were essential analytical tool to develop and refine emergent categories, which eventually were fine-tuned into six conceptual categories. Figure 3 on the next page illustrates the analytic movement from selected focused codes to conceptual categories to core category.

Figure 3

Analytic Process From Selected Focused Codes to Conceptual Categories to Core Category



Conceptual Categories

Data analysis revealed six conceptual categories. The categories represent empowering processes that were playing out across the variety of interventions and initiatives undertaken by the participants to address historical trauma at the community and society levels. These key processes manifested differently and in varying degrees across the participants' interventions. Each of the conceptual categories is presented and discussed in this section.

Holding the Space

Holding the space for people to "find their truth" (Emma), own their stories, and make new meaning of their life situation was one of the key processes identified by the study participants. Most participants affirmed that their primary role when working with communities and groups affected by historical trauma was to hold the space for the community members or representatives of cultural groups to come together to engage in a conversation and start on their healing journey. This empowering process was explicitly named by Emma and Julia.

> So, part of this is also helping people to find their own stories. I'm talking about trauma now. So, holding the space so they find the stories. (Emma)

> And since then realizing that we're just creating a space for healing, whether it's from the war, whether it's from Ebola, or colonialism. (Julia)

The participants identified a number of elements that were integral to holding the space for others to address the personal and collective impacts of historical trauma, including laying the foundations, allowing people to lead the process, nurturing trust, establishing safety, and attending to personal needs.

Laying the Foundations

Several participants reported that they would never intervene in a community or country before conducting the necessary groundwork. They emphasized the importance of laying the foundations that enabled them to hold the space for people to come together. Although the nature of the groundwork varied depending on the type and the setting of the intervention, and the professional orientation of the participant, it generally involved immersing oneself in the cultural context and connecting with local people and leaders.

Some participants involved district and community leaders in the planning and organizing phase of the intervention. Nathalie met with the community organizers prior to every intervention to gather relevant information about the community, including expectations, strengths, significant positive and adverse events during the past year, what the people identify as success, and how the community celebrates. She also asked the community organizers to identify the people whom they felt would be important to join the intervention and to select a group of people from that community to work on the intervention team.

> We do a lot of groundwork before we go in. And part of that groundwork is, one of the things I tell the organizers is I won't come in unless you give me people to work on my team from the community. … So, the first thing is we want to know what your expectations are. We want to know what's significant events have taken place in that community in the last year, and not only those things that people would consider trauma. But what significant events of resiliency have happened within that community during the last year. We want to know what celebrations, what typically people celebrate, how they celebrate, how they come together. We want to know what the strengths of the

> community is. What does the community identify as success? It's not important what we identify as success. But what do they identify as success?

Julia and her team, in her project in West Africa, carried out initial consultations with a diverse and representative group of district leaders, who later became involved in the planning of the intervention. She explained that the consultation meetings with the district leaders ensured that the communities in the region were all on board for the intervention.

> That process actually starts with the leaders at kind of like a district level, which is like a state, where women leaders, traditional leaders, political leaders, leaders of organizations that are active in the area, they are all brought together to learn about what this process is, the organizing process, so they can really, you know, think about it for themselves, and always have a choice, you know, if they want their community to engage in this or not, or if they want to participate.

In certain cases, particularly when the intervention was being conducted abroad, the participants, or the organizations for which they worked, partnered and collaborated with local organizations that already knew and had built trust with the communities. In her project in Central America, Renata and her team collaborated with a global non-profit that was already established in that region and had a relationship with the local community leaders.

> There we worked with an organization called [name of organization]. And so they had been working in, in [name of the region] for a while and so they were sort of our first contacts. Because they knew, they'd been working there for a while. They knew the community leaders.

Similarly, Julia and her team partnered with a local organization when intervening in a country in West Africa. “My organization has partnered with a [name of country] organization that has

created a process to support communities in determining how they want to heal, first from the war that happened, and then after Ebola hit, from Ebola."

Other participants spent a significant amount of time in the local setting observing what was going on and meeting with people to identify key players in the community or society, and to better understand the social and cultural dynamics of the place. Ezra highlighted the importance of networking and conducting a network analysis to identify central community players to join the conversation before implementing the intervention.

> So usually, if you're going in to do something like a [name of the intervention], you don't go into a community and this be the first thing that you do. Like, you will have been in a community doing small listening, personal network analysis to see who works with whom. … You're networking and you're doing the network analysis and you're trying to figure out who are the people who can help you, right? And so it's a process.

Pablo stated that the intervention team had to first understand the situation of the country or region where were working before they brought conflictual parties to the table for dialogue. As a psychiatrist, he adopted a medical approach when conducting preparations for an intervention by first assessing the situation through extensive information gathering and then making a diagnosis. This process usually took the team around six months to one year, interviewing people, mostly civilians, but also senior government officials.

> When we were invited to a country to deal with issues, we did it in a medical way, you do not treat anybody without a diagnosis. First spend six months or some- In Estonia for example, we spent one year, going every four months, talking to school kids, taxi drivers, presidents, parliamentarians, rectors, but mostly kids, to find out what's going on.

Allowing the People to Lead the Process

For the study participants, holding the space meant allowing the people and the community to take charge of and lead the intervention. Several participants portrayed their role in the interventions as that of a facilitator, inviting and supporting people to engage in a conversation or dialogue with each other to address their problems. Other saw themselves as a witness, listener, or translator.

> So the facilitation is just the facilitation. I don't actually need to know what's happening in the context. If I ask them the questions and give them the space, they, they do that work. … So the facilitation is in just feeding them back their words until they can distill it to the place where it's, where they can see it. … I don't need deep understanding. I need a little understanding just enough to stay out of their way, just enough to not be in their way as they're having these important conversations. (Ezra)
>
> I actually don't call myself a therapist. I call myself a witness. I find it easier to work within the parameters, that I'm a witness. (Kevin)
>
> I saw my role as, to be the listener and translator to make sure that what was happening, like the intervention was chosen by the community and was what the community wanted. (Renata)

Most participants argued that it was not their place to tell the community members partaking in the intervention what their needs were or to dictate how to address their concerns. Their primary responsibility instead was to listen to the people and the community to understand their needs, and to give them the space to lead the way. The participants emphasized the need to stay open and of not forcing one's agenda on the people.

> And I think sometimes it's listening that helps us to see where we need to go, what's happening. … So, I knew the history of Australia, I knew that. But where I was taught the most is at the community level, when I chose to respond to a request, and I just sat quietly and listened. And then in the listening, we would create ways of responding to our needs. (Emma)
>
> So what our team is directed to do is to go with the flow with participants rather than them having to go with our flow. (Nathalie)

Pablo emphasized that when he brought representatives of conflictual groups to the table for discussions, he was not there to instruct people what to do because he was a psychoanalyst and not a diplomat. "When we brought enemy representatives together [pause], I was not a diplomat. All I knew was I don't tell you what to do. I listen to you, I help you to find out solutions and so on."

Renata explained how the intervention she delivered in Central America unfolded differently from what she and other team members had envisioned. As part of a post-war healing intervention, the community requested assistance to exhume the remains of loved ones who had been buried in mass graves during the genocide so that families could properly bury their loved ones.

> It wasn't our plan to, to go in and hire legal support and forensic support, but when we interviewed that community, this, this was what was requested by the community. … As a practitioner, I learned to be really open and humble and, and listen, because the project ended up totally off from what I thought.

The same approach was adopted by the mental health counselors who participated in the study. Johanna and Simone offered also individual therapy in Indigenous communities in Canada and they both advocated "following the lead of [the] clients" (Simone).

Cultural humility was another important aspect of facilitating the interventions. Several participants mentioned trusting the wisdom of the people and the community to know their needs and how to respond to the challenges facing them. They acknowledged that the people had the answers, and solutions had to be sought from within and not imported from outside.

> It's like the answers are in the community, the answers are in the people. … And when you put them all together, you come to a deep understanding that the answers are already there. We have to slow ourselves down. We have to be responsible as clinicians, as practitioners. We have to get rid of our ego and think we've got the answers [emphasis]. (Emma)

> So, I don't believe any more that government has the answers and they will deliver. I believe people will deliver. … I have the most faith in [the] community. When I get asked to do something by a group of people, I know they're serious and we get out and do it. And I see them solving problems, always [emphasis] choosing to go into the pain so they can move through it and be strong. (Emma)

> I would say the humility piece of really listening, going in without an agenda, and being willing to change what you thought was needed. Like really trusting that people have their own, everything they need, and their own wisdom is really foundational to this work. (Renata)

Wendy expressed frustration toward mental health professionals who go into a community and assume that they can prescribe what people need to do to help themselves.

> You know, step into a community and shut up [emphasis], especially if you're not from that community. Because lots of times they send people into our communities who are not from the community, and they're in there, you know, telling us, "Oh, this is how you help yourself. This is what you need to do." And, you know, and they're not listening at all [emphasis]. They're not understanding that these people just need somebody to facilitate their conversation. Let them have their conversation. And you're not there to tell them what to do.

Julia echoed this same sentiment, when she claimed that sustainable change and transformation can only happen from within. She criticized elitist and bureaucratic institutions such as the United Nations that try to enact change from the outside. “That’s not where I think problems are solved. I don't think it comes from the top. It doesn't come from the outside. It comes from [the] people within the communities.”

For the participants, cultural humility also meant that they did not assume that they knew better than the community because of their professional training or knowledge, but instead they allowed the people and the community to educate them. Emma and Wendy expressed how much they learned through their experiences in Indigenous communities.

> By choosing to also be out on the ground, I was learning more all the time. And what I was also learning was to start to listen more deeply, not to assume I knew because of the academic background I had and what I had been taught. (Emma)
>
> But I learned a lot from the people living there [North Canada] about, you know, what they were up against. (Wendy)

Nurturing Trust

Holding the space for people to come together to share, emote, and have dialogue hinged on the practitioner's efforts toward building trust among the people and within the cultural context where they are working. Nurturing trust was another fundamental aspect of "holding the space" that was unanimously identified by the participants.

Many of the participants noted that building trust was critical to the success of their interventions. Johanna believed that it was easier to implement an intervention when the practitioner had already built trust with the people. "I think there is interest for it [group work] and I'm actually thinking about starting something up maybe next year because I have built up trust within the cultural context." Participants pointed out different strategies that helped them infuse trust in the process.

Julia and Pablo argued that it was important that the process was open and transparent for everyone.

> Well, I think it starts in both cases [referring to the two projects she had described] with building relationships and trust. And then in terms of facilitating, being very clear and transparent with people about what it is that we were coming together to do. What the motivations were to do this, what to expect, you know, when we got together. Making sure that it was completely voluntary. (Julia)

Pablo stated that a core principle that governed his work with representatives of rival groups was maintaining transparency with top government officials at all times. "And never do it secretly from governments. Never do it secretly."

Ongoing consultation with regional and community leaders, and especially with traditional leaders and elders, helped to nurture trust and a better understanding of the needs of the people.

> And then I, I think my role really is to follow the lead of some of the leaders in the community. So I often will go in, and I might be working under one contract umbrella that has a certain mandate, but I usually try to make connection with people in the community that, that sort of hold some responsibility. And I will try to, to say, "You know, this is the work that I'm hoping to do, does that make sense for where your community is at right now?" (Simone)

Simone also talked about the importance of preserving the trust even in difficult and sensitive situations, such as when she was receiving multiple disclosures of sexual abuse from children and had to do mandatory reporting to the authorities.

> So I had a number of conversations with different people at different levels, just kind of saying, you know, "Is there, is there anything I need to be doing differently?" Or "Is there anything that that would help in terms of shaping this social evolution that's coming from the small ones?" … It's still painful, but I think, I felt better having just kind of checked in.

In some cases, the participants started "building a network of trust" (Julia) right from the outset of the project, while they were laying the foundations for the intervention and establishing rapport with local organizations and community leaders.

Some participants claimed that being authentic as a practitioner is essential to foster trust among the people or in the cultural setting.

> Often it's just bringing our full humanity with others, and providing space for them to do that too. (Maya)
>
> I know in the, in the fields in which we work and in the academic world, you know, you're not supposed to bring your personal self into it and that's wise. However, I tell people, you know, "When you go out into a community to work with the community, you have to bring yourself along." … It's about saying, "I am a human being just like you. I bleed, just like you. And I'm here because I feel strongly about how important it is that we feel well, that we work together to do it." … People working in this field have to be, like authentic individuals. (Wendy)

Establishing Safety

All the participants underscored the significance of creating a safe environment where people could share their distress and engage in difficult conversations on sensitive topics. Safety was a foundational aspect of "holding the space" and all participants strived to honor and address the safety needs of the people partaking in the interventions. However, the way they approached safety varied depending on the nature of the intervention and the context where it was taking place. Additionally, the participants attended to different dimensions of safety, including physical, psychological, relational, and cultural.

Participants often addressed safety at the beginning of the intervention. It was usually incorporated into the ground rules of the intervention. It was also reflected in how the participants supported the people participating in the conversation to broach sensitive topics and have productive interactions.

> "And so, we made a lot of commitments as we were going to work together. There was things like, no alcohol, no drugs, no non-prescription drugs." (Emma)

> "It was important to ease people in through personal storytelling, [and] opportunities for people to get to know each other as human beings." (Julia)
>
> "So we go from safety, which is on the beginning of the curve, to Wednesday, which is a lot of emotion." (Nathalie)

When inviting representatives of conflictual groups to engage in dialogue, Pablo paid attention to the identity threats that could influence the outcomes of the discussions. He worked to remove any threats to the large-group identity of the parties involved in the dialogue.

> I wrote all these different things about how you deal with identity issues, how you bring opposing people together, because the tendency was, when you brought opposing people together, you know, they engage and make them lovey-dovey. That is so scary, because you lose your identity. So we developed the idea that when we bring people together, keep a psychological border, so they can keep their identity secured, they can make more realistic discussions. … The threat to their identity has to be removed."

Some participants claimed that emotional safety was enhanced through the group process. Julia explained that being surrounded by other community members provided a sense of security for people who came forward to share their painful stories. "Their community was holding them in sharing their story. One person speaking enabled other people to speak and to come forward." Similarly, Renata believed that stigma and shame are better held in a group setting.

> Also another piece of the community or the group-based model is, is again that stigma piece. So we're talking about issues that are very sensitive. It's so much better held in a group, I think, than in one-on-one in terms of shame and stigma especially. They can be diffused when in a group.

Some participants drew attention to the importance of protecting the privacy and anonymity of their clients. Johanna expressed hesitation about offering group therapy in small rural settings due to the difficulty of safeguarding the confidentiality of group members.

> Because if, you know, the person that you work with every day and they also go to the same grocery store with you every day, and is also in your trauma group when you're coming into town, how are you going to navigate that? And keep all of that information that is disclosed during the group shut down.

When serving in small remote communities, Simone was very mindful of the heightened threats to client anonymity. She noted that clients can potentially be outed by stopping by her clinic. Sometimes, Simone agreed to see clients outside of her office to protect their anonymity, although she explained that she does this very carefully.

> Occasionally, and now this is not often work that I personally choose to do, only because I work in such small places and the privacy can be difficult, but I have at times taken people out of the office and we're doing walks, you know, along the river or walks by the lake and talking as we're walking. … So I'm cautious to do that only because, as I say, the places I've worked are so small and often I might be the only non-Indigenous person in the community.

In some cases, the participants had to safeguard the physical safety and integrity of those involved in the intervention. When brokering dialogue between representatives of rival groups, Pablo tried to avert the media spotlight that could have endangered the lives of the people engaged in the talks. "Our biggest help has been that nobody got killed. We opened dialogues and the dialogues included no media, so nobody knew about this. This is why we didn't get killed."

A few participants expressed concern about their own physical safety when serving in small isolated communities.

> You can be a little bit of a target when you are working in small places, and you're highly visible, and you're doing things to empower children and women, and people that generally don't have a lot of voice, right? You can become the target of some, some real anger and violence even. (Simone)

Simone explained that she tries to work outside of her home community to mitigate the risk.

Most of the participants talked about the necessity of cultural safety when working with communities and groups affected by historical trauma. The goal of cultural safety is that everyone feels that their cultural identity is honored and valued.

> So having an understanding that everybody comes from somewhere and, you know, having that empathy for, allowing them the privilege of being from that place [chuckles], and entering their experience is really another part of this. (Wendy)

The participants addressed cultural safety through different means. Emma explained how she invited the group members participating in one of the interventions to acknowledge "that we were a diverse group and we had the right to our diversity. But we also had to respect each other and honor each other." Simone stated that when she is working in an Indigenous community, she follows the lead of an Indigenous elder or somebody with knowledge in the community to find out what is culturally respectful. "I'll follow their lead on what is an appropriate and respectful, culturally respectful way to work within that community." Simone also shared that, over time, she started to follow her clients' lead and increasingly incorporate language around the spirit in her one-on-one interventions.

> So I have noticed that I have, as a practitioner, really opened up to talking more and more about spirit, about things that aren't seen, because I've been following the lead of these clients, and, and it is very much what is needed, very much what's needed. … I think also for the work to be effective there has to, the person has to fully be able to come into the room, and not like, it's not just their body. There's their soul, their psyche. Everything must be accounted for.

Similarly, Nathalie tried to take into account the different spiritual practices exercised by community members in her community interventions to ensure that everyone's way of praying is validated.

> So I want to know what the, you know, what the spiritual practices are. So we might be in a community and I might have somebody that is Christian open and somebody that is traditional closed. So what we're modeling constantly is we're one big circle. We might all have different ways to pray. But it all goes to the same place. And we're all, you know, so functioning on the values of kindness, respect, inclusion and belonging. And what happens is people that would never stay in a circle when somebody, for instance, is lighting a pipe, they stay in the circle because they know that we also respect and value their way of prayer.

Some participants paid attention to the diversity of the planning and the intervention team. Julia made sure to recruit the support of a diverse team to hold the space when serving on the project that brought together the descendants of former enslaved people and descendants of former slaveholders. "We were very careful in terms of [the] people that we hired, our staff, to make sure that we had people who had different experiences and perspectives." Julia and other team members, in their project in West Africa, tried to make sure that the organizing process was

representative of the diversity of the communities and that "everybody's voice [was] represented," especially women's voices. "Because it's a community-wide process, it has to have input from all stakeholder groups within the community." On the same note, Renata highlighted the importance that the facilitators she trained to hold the space in healing circles were members of the same community where she was serving. "So I facilitate some of the groups and then I train the facilitators of some of the other groups. So, again, like we want the groups to be led by people who are part of the community."

At times cultural safety meant providing a space for people to heal within the safety of their own group before engaging in the broader healing process across racial or other forms of divides.

> Sometimes the groups are mixed groups where there'll be some White people in. And what I generally sense is that people are nervous to talk about it. I think in South Africa, either you talk about it openly, or you are hesitant to talk about it. So, I think that that often happens. When it's an all-Black group, then people feel free to talk about it. … Sometimes healing needs to happen within your own group because healing cannot always take place when you have different racial groups together. And I think that there are levels of healing. (Zora)

Another aspect of cultural safety was language. Some participants were mindful of the language that people use to express themselves and gave permission to the group members taking part in the intervention to speak in their preferred language.

> We need attention to language. So several of the places I've gone, I think it's important for people to grieve in their own language and also to be able to speak that in their own

language. So we do a lot of simultaneous translation. Some of the places I go, I have earphones and so do all of my team. (Nathalie)

We give the people the option of speaking to each other in their own language, right? So I'm an English speaker and I don't speak Oji-Cree, but if it makes it easier for them to speak, then it's like, "Go ahead. You know, you can translate for me later or you can share with me what you want." But you could talk the way you need to talk in your own language because it's easier for you and [the] people will listen to you. (Wendy)

Wendy adopted the same approach when she worked with young people. She gave them the choice to express themselves in a modality that felt comfortable to them.

Or maybe, like with kids I'll say, "Here's a rock or a feather, we're gonna pass it around, and when you have that rock in your hand, you have the floor. Nobody will interrupt you. You can speak as long or as short as you want." And, and so they do. And then, but I'll say, "But if you don't, if you can't bring yourself to speak out loud, I've put paper on the floor with markers. You go and draw, and you can draw a picture, or you can write out what you want to say, and that's okay too."

Several participants claimed that one of the imperatives of working with communities and groups affected by historical trauma was to do no harm by recapitulating the same relational power dynamics that led to the present-day predicaments facing the people and communities.

The first role would probably be to do, if not to do any good, to really do no harm. And, as best as possible, try not to recapitulate the experience of colonization." (Simone)

Renata emphasized the importance of allowing the people to lead the intervention process because it serves as a means to reverse the relational dynamics that brought forth the historical trauma.

> Another layer that I think exists in, or I try to make sure exists in any intervention is that these communities have, like their power has been taken from them. And so making sure that any intervention is led by the community is actually in of itself trying to undo that dynamic. And so regardless what the intervention was, if like, it was very important to me that the community decides and take charge of what they wanted to do and own that because of the historical piece where that was taken from them. So that feels like an, an integral piece of any intervention.

Several participants drew attention to cultural identity and the importance of being aware of how one's cultural identity can impact relationships with people from different cultural backgrounds and the intervention process itself. This point was largely emphasized by participants who identified themselves with the dominant culture or were non-homogeneous with the culture of the community or group. Some participants stated that they viewed their work as a way to make amends for the historical and present-day harms or as an offering of reconciliation.

> I know I inherit certain privileges and luxuries based on my whiteness that [name of a specific Indigenous group] and Indigenous people do not have, and so what I represent is this memory of betrayal. So I view my work as paying a debt. (Johanna)

Renata was mindful of the impact that her American identity could have had on the trust building process when she was working in a community in Central America.

> And there's a lot of, you know, frankly, like, I'm American and so the U.S. had a huge role. So I'm very sensitive to the fact that, like, of course, there'd be mistrust and resistance. And it makes sense. So, yeah, I think just like keeping in mind the historical pieces and, I wouldn't call it a hindrance, but like barriers to the process of building trust.

Renata argued that mental health practitioners must practice self-awareness around their cultural identity and what their identity might represent to other people from other cultural backgrounds. She emphasized the importance of looking at the historical aspect of one's cultural identity. "And then the third piece, I would say, is really educating yourself on the historical piece and knowing what you might be representing."

Julia did extensive co-counseling around racism while preparing to facilitate groups that had different experiences around the history of enslavement. She considered this personal work as "the heart of the practice."

> So particularly with the folks who had done a lot of co-counseling around racism, right? So it was something that we had explored individually. We started looking at our own story and experience. So I think as a facilitator, a group is only willing to go as far as those who are holding the space are willing to go.

Simone talked about the importance of broaching with the clients on her cultural identity at the beginning of every therapeutic relationship when working in Indigenous communities in Canada. She called attention to the need to give clients permission to talk about the cultural differences in the therapeutic relationship and issues related to historic racism and discrimination.

> I try to name it myself early on to set the tone and set the frame and normalize what's going on. And I'm also, again, really conscious of the fact that I could for them represent all sorts of things, right, because of my social identity and white skin, and all that. … I'm also trying to give permission that, you know, if this doesn't feel okay, let's figure something for you that does. … I know that you're likely experiencing or your family is experiencing different levels of racism that I couldn't imagine walking through every day.

> And bring it here because that's okay to talk about." So from the very beginning, I'm hoping that that's a part of the conversation, or at least it's like in the room. And then I'll usually leave it to them if they want to go there. … In a way I want to try to stand with them in solidarity.

Additionally, Simone addressed the significance of being able to sit with the discomfort of being perceived as part of the perpetrating group because of her whiteness.

> And I think that, you know, you think that being a person with my background doing that work in community, I do tend… It's not easy to do. I'm often soft and uncomfortable, right? But I think that there's, the act in itself is a piece of reconciliation, you know.

Zora, on the other hand, noted that some White mental health professionals struggle to bring up issues of race and historical trauma as part of their interventions with clients.

> The amount of Black psychologists is limited. So, if people want to access that sort of therapeutic services, they can end up having a White psychologist. And I can tell you, very few White psychologists are willing to look, in South Africa, are willing to look and address- … It's a struggle for them to include race and historical trauma in that sense of the word.

Attending to Personal Needs

Most of the participants addressed the importance of working on themselves and engaging in personal therapy in order to be able to hold the space for others to heal. Some participants asserted that they cannot hold the space for others to work through their suffering unless they have done their own personal work. Some participants had to deal with their own traumatic experiences, whereas others had to come to terms with the same historical trauma impacts that were afflicting the people and communities they were serving.

> One thing I would say is, "What's supporting you in your work?" Like, "Have you taken the time to think about your own, own trauma and how, how this connects to your purpose in your work?" Because I really believe that our own process of healing is really connected to the work that we do. And when I have to face my own difficulties and, and life traumas, that makes me a better practitioner because I'm able to be on the other side and realize "Ooh, this is hard work," you know [chuckles]. (Renata)

Maya advocated "commitment to ongoing self-work" and doing her "own work in parallel with helping others." She explained that she had access to separate resources that help her process what comes up for her during her work. Zora stated that as a Black South African she had to come to terms with her own personal heritage. She explained how she wrestled with the "idea that I cannot make it up for what was lost and I cannot replace all histories and all of what we are going through, all of that, as well as discovering my own sort of slave heritage." Over time, she began to see her work in the field as her activism. Zora emphasized the importance of staying authentic and acknowledging that while "I enjoy the work still and I get moved by it. … But there's an acknowledgement that I can go to a space, and then I have support."

Self-care and clinical supervision were also identified as important aspects of working with communities and groups affected by historical trauma. Emma stated, "I can't listen if I'm not caring for me." She mentioned that she had a list of people to whom she could reach out when in need of help or in crisis. She also turned to artistic leisure activities, such as painting and poetry, whenever she felt the need to unwind.

As an educator, Simone encouraged students to access clinical supervision and attend to their self-care needs.

> I'm trying to get them to develop a way of working in which they're really listening to them, to their own selves, to their own hearts and nervous systems, to try to truly pace at a level that makes sense to who they are.

She explained that some of the violence that she came across in some communities "can be really disjointing" and it is therefore important that mental health practitioners have a safe space where they can practice self-care that prevents them from getting mired in the grimness.

> So having, you know, places that aren't that, that are different than that, that are beautiful, that are, that are very, very safe. I think the opposite, is, is really important. You can get a little bit lost in it, I think, sometimes. The risk of getting lost in it.

Nathalie incorporated daily debriefings for the intervention team when she worked in communities.

> I make sure that each one of my team debrief any of the triggers they've had during the day. First to take care of them, what they need from the team, and then who they're worried about in the group, how we're going to take care of those people the next day and do wrap around services for them to make sure that they're safe

Several participants drew attention to the personal and professional costs of working in this field, including the high rates of burnout, compassion fatigue, and secondary traumatization among practitioners, which often result in an array of explicit and hidden impacts such as relationship breakdowns, "leaving the field prematurely, leaving the work, [and] leaving the community prematurely" (Simone). As a result, some participants decided to offer clinical supervision and emotional health support services to front line workers.

> When you're intervening and working in those communities, that's likely to have an impact on. So the impact of that, I think, on frontline caregivers is pretty significant. So

now the research and the work I do is mainly clinical supervision and support to people that are working within those contexts. (Simone)

I think it did start in Rwanda when I was really noticing the effects that, that vicarious trauma can have on practitioners, and what happens when a practitioner leaves, all the effects that that can have. And so, you know, I began to think long-term, if we're really gonna make shifts, we have to be investing in the people who are doing the work of trauma healing so that they can continue the work in the long run. (Renata)

Renata also highlighted the overlap that exists between practitioners and community members. She explained that "very often the practitioners are part of the community." Both Simone and Renata argued that clinical supervision and self-care ensured the longevity and sustainability of the work that they were doing.

"You can't get too much probably is what I want to say to people to take care of yourself. … I think it's core to the longevity and sustainability of the work. Longevity to be able keep doing it." (Simone)

Naming the Problematic

Another empowering process identified by the study participants was helping people analyze critically their present situation and conditions, and to name the problematic in their life stories. All participants affirmed that giving people and communities the space to identify and confront the challenges and barriers that were impeding their "full flourishing" (Ezra) was one of the central goals of their interventions. Many of the participants claimed that naming the problematic was the first step toward healing and empowerment.

You don't get to the positivity until you've dealt with the truth." (Emma)

That's the other thing, that I think is the same whether an individual, community, international level. You have to name what's going on to be able to heal it. You have to identify it. And, so for a community to identify what those cracks are is critical. (Julia)

Julia used the analogy of a cup to illustrate this empowering process in the communities with whom they were working in West Africa.

And the metaphor that we use is a cup, usually a water bottle, because that's what's available. We cut the top of the water bottle off, and poke holes in the cup, and say, "This, this is the community." Right? "And what, what happened, you know, after the war, during Ebola, is that those outside the community, whether it's the government or international organizations, they came with their water and they poured. And what happened?" Right? In [name of language], the what a [the water - pun on water] waste [both laugh]. So the international community, what did they do, "Ah, it didn't work. Let's, let's pour some more. Let's pour some more." When, when the work that's needed is repairing the cup. First of all, seeing that there's a cup, and I think that, that relates on the individual basis as well. Seeing that there is a wholeness, right? A wholeness that has been harmed, you know, that there is, there is breakage.

As part of this empowering process, people are helped to make meaning of whatever is happening in their lives and around them, and to own their stories. As people experience increased awareness, they are able to situate their personal stories into a broader context. People start to realize how their personal accounts of adversity and disarray are part of a collective story that reverberates wider problematic social patterns that are contributing to the present-day harms. Mental health practitioners, on the other hand, must adopt a systemic understanding of the

challenges and hardships faced by historically marginalized communities and groups to facilitate this empowering process.

Owning Your Story

People and communities must own their stories in order to name the problematic. All the participants reported that people had to first make sense of what was happening in their lives and in their communities, and construct a coherent story that accounts for the suffering and the strife that they see around them.

> It's the stories that help us make sense of the things that are happening. … So, part of this is also helping people to find their own stories. (Emma)

Several participants mentioned that the people oftentimes can identify the problematic in their lives and in their communities; they only need a safe space to own their stories.

> If I give them enough time to name the problematic, they'll name it. And then when they're having trouble and they describe all kinds of things and you work with them. (Ezra)

> And when people see that, when they come in the cracks, they can just hone right in on exactly where those cracks are [chuckles]. Everyone knows, everyone knows what those cracks are, and there's something about it that makes it less personal. It's not their personal failing. It's just like, "Oh, those, those're the cracks that need to be repaired. (Julia)

The people's stories generally revolved around the impacts and legacy effects of historical traumagenic events on families, communities, and societies, such as suicides, addictions, domestic violence, child sexual abuse, community conflicts and violence, and poverty. Most of the study participants noted that when they were called in to intervene in a

community or region, they were usually asked to respond to present-day impacts rather than to historical trauma per se.

> So, we've had, we had a spate of suicides in a remote community in Western Australia. And the health workers- So now I'm talking about the Aboriginal Health Services. And the health workers there didn't quite know how to respond to a family where two young men had hung themselves. So, they asked if I could come in and we would run a workshop up in the, you know, out in the country. (Emma)
>
> The idea is to address the current manifestations that are producing harms today. (Ezra)
>
> It's now not just about trauma healing. It is about looking at some of the serious conflicts that have happened in the community, that have torn people apart, that have impacted people individually. (Julia)
>
> The things that tend to come up are around racial trauma, specifically gentrification that's happening here, and in general, the U.S. Like, I think there's a lot of, a lot of uncovering is happening right now around equity and inclusion. … I mean, I guess the underlying factor is like lack of, lack of power, lack of control over these basic, basic needs like housing, or like where my children go to school, or how my children are treated at that school, you know? (Renata)
>
> So, I mean, whole families struggling with addictions, PTSD-like symptoms, poverty, homelessness, not able to find consistent work, a lot of relational trauma, a lot of difficulty with trust and establishing and maintaining trusting, helpful relationship over time. It's a lot of disruption that's like ongoing. (Simone)

> And then the level of addictions in our communities and the level of depression and violence, domestic violence, sexual abuse, all of those, you know, what we call legacy effects. (Wendy)
>
> Despite apartheid being done with, we still seem to be living in this legacy of the past. … There are still huge pockets of poverty, there are still huge pockets of White privilege. You'll think that we're still living- You'll think that it's just not law that the communities are still very divided, not necessarily against each other. But the wealth, in the same way that trauma is intergenerational, wealth and privilege is intergenerational as well. So the divides are still there. We really are one of the most unequal societies in the world according to one of the indexes that was done. (Zora)

Some participants reported that sometimes the presenting problem was only the tip of the iceberg, and the interventions helped to expose deeper, hidden problems.

> What I've learned is to never assume I know, to understand that what presents first is not the story that I need to understand, that it comes later. I stay and I stay. (Emma)

Owning one's story meant speaking the unspeakable and confronting issues that had been shrouded in silence and shame for far too long. The people who took part in the interventions were able to step away from the shame and denial as part of this empowering process.

Emma referred to a number of community interventions in which she uncovered underlying issues that were causing considerable distress to community members and were feeding into the presenting problems. She explained how one time she was asked to respond to a string of suicides in a remote community in Australia and unwittingly ended up unearthing disturbing facts that had never been publicly disclosed.

> And then some of the women who were the young fellows' aunties started to joke around a bit and talk about what it was like at the mission that they had been removed to as children. And that was the child removals. And they were saying what a good thing it was where they were in that mission, how much fun they'd had together. And it was kind of a spontaneous activity of laughing and thinking about that, talking about that. And then, all of a sudden, one of them jumped up and she was really angry. And she challenged them, and she said, "You know what happened to us in [name of mission]. We were all abused sexually" [angry tone]. And it was like a bomb going off. It was like something in the whole place stopped because she'd spoken the truth that nobody else wanted to, and nobody had talked to previously. This was the first time that was named.

Similarly, Pablo highlighted the importance of paying attention to the psychological issues fueling the tensions between conflictual parties. He claimed that psychological resistances are usually at the heart of long-term unresolved conflicts. Although his team dealt with the realistic issues when working with rival groups, such as disagreements over country borders, as a psychoanalyst Pablo was more concerned with the psychological issues and how these influenced the dialogue and relations between the opposing parties.

> If there are realistic issues obviously you need to deal with the realistic issues, and if they're not psychologically, not contaminated with resistances, diplomacy is a profession, that's what they do. But most of the chronic unresolved issues are psychologically contaminated, like Arab-Israeli, Turks and Greeks for example. All these things need to pay deeper attention to psychological issues.

Following the dissolution of the Soviet Union in the early 1990s, Pablo delivered interventions in several Baltic countries to help opposing parties achieve a peaceful transition. He drew attention

to the psychological issues that began to surface in Estonia once the initial jubilation following their independence started wearing off.

> Can you imagine you're such a small country and you suddenly become independent? They were singing, etcetera, making things, but then we went there, and you know what we found out? A society in depression. See, then psychological issues come up.

Pablo also noted how the psychological issues played out when Estonian representatives were addressing Russian representatives during the intervention.

> And they could not, they were not able to express angry feelings against Russians when they were talking because they were afraid Russia will come and get them again. Because their history is that always somebody ruled them. They could not stay independent long enough, not more than three years, you see?

Some of the study participants highlighted the importance of the collective aspect of meaning making. People seemed to make sense of their situation through the stories of other people which enabled them to own their stories. The participants argued that all stories are part of a collective as much as they are personal. Together with other community members, the people were able to weave a collective story. When facilitating interventions, Emma reminded community members "that our stories were all part of the whole, the collective."

When working on a national project that addressed the legacies and aftermaths of the institution of enslavement in the United States, Julia observed how people constructed meaning around their personal stories by noticing common elements and patterns across the experiences of other people.

> I think, you know, what was happening with that group of people is they were weaving a collective narrative. They were identifying the patterns that had gotten passed down.

> They were looking into what had happened in their individual families. They were noticing there are similarities across their experiences.

Julia pointed to a similar dynamic when discussing the intervention she and other team members delivered in West Africa.

> When people are trying to address the experience of war, they, people need each other. People need each other to help construct their own stories. And, you know, one of the effects of trauma is you become frozen, right? You can't, you can't tell your story as a story. It's just, it's something that gets frozen within you and then it impacts your behavior and your physical experience. And when people come together, they have a- Even though people's stories are individual, they're also collective. They hear each other's stories in, in each other. So as somebody is brave enough to speak what happened to them, it helps loosen other people's stories. It helps them face what happened to them as well. … It's like as somebody is reconstructing their story, if there's a bigger story that's being constructed, there is an ability to bring your own story into that bigger story.

Uncovering Broader Patterns in the Story

Several participants claimed that it was important that the people were helped to develop a wider understanding of the problematic in their stories and to identify larger patterns that were contributing to the problems that they were witnessing in their lives and in their communities. The resulting increase in awareness enabled people to realize how their predicaments were not necessarily attributable to personal failings or shortcomings, but instead reverberated larger problematic patterns that shaped the lives of individuals, families, communities, and entire populations.

Emma talked about a school intervention in a community in Australia during which she uncovered rampant child sexual abuse, a problem that had been long overlooked by the authorities.

> And then if we listen more deeply and, and we see with different eyes, we see that there's problems, maybe not just in their families, but in the community itself, and in the social system itself. And we also saw that the Department of Education was failing them totally. It was easier to say these were bad kids.

During the interventions, Ezra focused on the narratives that dictate how society is organized today, and which shape the present-day circumstances of both marginalized and privileged groups in society. "What I want to do is allow them to notice that their privilege and your lack of privilege are responsive to the same set of conditions." He argued that "it is the narrative and the discourse, usually that we can't see, that shape institutional structures that shape relationships that identify and, and determine the distribution of resources, and testimonial authority, and power in a community." Narratives "shape the possibilities for how you can act today and the trajectory that you have for your future." Furthermore, Ezra believed that "it's our narratives and stories that tell us how to feel, that tell us what meaning to make." He thus helped people to become aware of the narratives that fueled present-day manifestations of historical trauma and "impede[d] people's full flourishing". This process enabled people to develop critical consciousness.

> If we say that the people aren't the problem, the problem is the problem, how do you name the problem? … And then they start saying fear and this, you know, separation, and misalignment of resources, and our community and cultural practices. And you get them to name that.

Julia claimed that shedding light on the problematic patterns that justified a decade-long civil conflict in West Africa, allowed survivors and perpetrators to confront the horrors of war and engage in post-war healing side by side.

> I think you also realize that what happened to you is personal and it's not personal. It's part of a bigger story, a bigger pattern. The perpetrators, you know, in a particular war situation they were being governed by a whole pattern of thought and action. And, there are many people, there are many, a lot of child soldiers, people who were being drugged and conscripted. And [pause], so that the craziness, the frenzy, the frenzy that came about during that war situation, it wasn't individuals' choice, it was much bigger than that. It was much bigger than that. And these, these bigger patterns, whether we're talking about war, whether we're talking about colonialism or racism, it's this, it's a bigger pattern that people get engaged in. It's not just an interpersonal experience. And in some ways, that's overwhelming, but in some ways, I think that can be helpful as for working through trauma, especially collective traumas, just to recognize that it wasn't just me, it wasn't my fault.

Pablo identified large-group identity challenges as the basis of endless hostilities between cultural groups and populations. He consequently honed in on large-group identity issues when he facilitated dialogue between representatives of rival parties.

> So what I learned by working with the Arabs and Israelis, and then the Baltic republics, and then the Soviets and the Americans, there is something called large-group identity, which is an abstract concept. You're a Basque, you're a Catalan, you're a Spaniard, you fight. You're Italian versus you are whatever, you're German. You're either allies or you're enemies, but you have somebody you fight, you kill. At the bottom of all these

> crazy world affairs, psychologically it's such a simple little thing. We kill in the name of identity, large-group identity.

Assuming a Systemic Understanding of the Problematic

All the study participants demonstrated a systemic understanding of the challenges faced by the communities and populations they served. They analyzed critically the role of larger systems beyond the community level in perpetuating historical harms into the present. The following interview excerpts illustrate the systemic perspective adopted by the participants on the individual and community impacts of historical trauma.

> And the societies in which we live are more likely to build another detention center and adult prison, or label the children as bad children, or the young people as just bad kids who want to get on the drugs, without understanding that it's all part of a whole. (Emma)

> Over time, conditions, traumagenic circumstances shaped and reshaped beliefs and then patterns of practices and relational patterns, such that we've now organized our society in ways that don't support everyone's full flourishing. And we organize[d] our society in ways that choose among the people as to who should be permitted to experience full flourishing and who should not. The discrimination of gender, of race, of ethnicity, of religion. We started making those decisions. Much of those decisions were based on historically traumagenic experiences and conditions. (Ezra)

Julia stated that it was difficult for her to name all the impacts of historical trauma on the populations with whom she worked because the signs are almost everywhere, some more overt and others more subconscious.

> And then there are other forms of traumagenic experiences that are continuing to happen through structures or culture. And, you know, I focus most on the institution of

enslavement in the United States and how that has been experienced, [pause] you know, in this country. And, you know, the traumagenic systems and behavior are continuing, right? So it's, so it's coming from the past [chuckles]. It's also continuing to be experienced through the structures. So it's not just coming from one's community and what has been internalized there, but one is continuing to bump into micro-aggressions or, you know, outright experiences of harm within the external world, even if they leave, you know, that community they're in. So it's complicated, right? It's complicated. It's something that people can't always put their finger on, right? Especially if it's within the culture.

Similarly, Simone explained how systemic racism adds another layer of harms on top of the historical grievances sustained by Indigenous peoples in Canada.

But then the fact that kind of systemic racism continues and that it's not widely acknowledged, it's not reconciled. There's been some public apology made in Canada, but I think that the moves have been really superficial, superficial to reconcile with our Indigenous people. And so the fact that it's those like a historical and a current present-day series of injuries, I think makes it really complicated because the system is not set up to really help these people heal or even to thrive.

Zora reflected on the modern-day vestiges of historical injustices that continue to harm Black people in post-colonial societies.

That's what I'm seeing in my work and what I'm seeing in the community, and what Black people and post-slave societies are seeing around the world is this repetition of [harms], just manifested in a different way.

Pablo, on the other hand, took psychoanalytic theory to a whole new level by taking into consideration the impact of historical, cultural, and political forces on group and geopolitical relations. He explained that "classical analysis did not pay much attention to external events," and even nowadays it is regarded as "something new." Additionally, Pablo extended the principles of psychoanalytic theory to explain large-group processes, which led him to develop the concept of large-group identity.

A few participants claimed that graduate programs that train mental health practitioners tend to focus exclusively on intrapsychic factors and individual behavior, often ignoring the community and broader social realities. This narrow perspective was considered extremely problematic for mental health practitioners who are working with populations affected by historical trauma.

> And I just want to say something, what I think I just said too, is that quite often universities are not teaching the cutting edge of what's happening at the community level. (Emma)

Nathalie explained that over the years she became more sensitized to the need for training mental health professionals differently. The urgency for an alternative training model that paid greater attention to community-based and culture-centered interventions inspired her to develop a graduate program for social workers through the Middleton-Moz Institute.

> So many people say, why would you be interested in community? … So that's one of the challenges. How do we change some of the rigidity, which is, again, one of the reasons why we started this school. It came from an elder stream and we began to, you know, educate people, social workers in a very different way.

Wendy encouraged students to do additional reading on trauma and historical trauma, as well as the history and culture of Indigenous peoples in Canada. She compiled a comprehensive booklist that she used in class and in workshops to refer students and participants to relevant literature on the subject. She argued that mental health practitioners should review these materials to broaden their understanding of the different levels of impacts of historical trauma on Indigenous communities.

> You know, you're asking me like, how can mental health practitioners address it? Is to actually get an education. I mean, there's plenty of material now to have that conversation from, you know, like there's a lot. The other thing I do is I actually encourage people to read, especially people that are going to be, are going to be counseling, that is to read some of the material.

Revisiting History

Many of the participants stressed the importance of helping people and communities revisit their history to understand the "background story" (Ezra) of their contemporary challenges, "where the historic trauma comes from" (Wendy). This empowering process enabled people to make sense of their life stories through a historical lens, and to take notice of the connection between what they were experiencing and witnessing in the present and the history of their community and their ancestors. As a result of this empowering process, people became increasingly aware of how problematic elements and patterns from the past are being perpetuated in the present. They also recognized how their behavior and meaning making has been shaped by the tides of history. At the same time, mental health practitioners must have a clear understanding of the history of the people and communities with whom they are working to facilitate this empowering process.

Mapping the Historical Roots of Present-Day Harms

Most of the study participants argued that communities and groups need to understand the source of present-day harms and acknowledge "the history that brings us to where we are now" (Emma). Many of the participants used the interventions to raise awareness among the people on the historical underpinnings of contemporary problems and help them situate their challenges within a chronological dimension.

> "Now let's imagine that your community is the play. What's the background story? What's the background story?" Just like in the play, there's background stories that they don't actually say. But you have to see it and understand it in order to understand the context of the play. "What's the background story for you? If somebody is observing your performance, what's the background story that they need to know to understand, how to understand your community?" (Ezra)
>
> The historical piece is important because it helps us name these patterns, right? And I think that's the importance of calling out something as historical trauma, is because it helps us go back and really point to what actually happened, right? Because as long as the stuff is invisible and we can't name it, we can't see it, we can't recognize it, and be aware of it, it will just continue. So that's, that's why I think it's important to look at the historical dimension, to point it out and look at how that links to what we're experiencing right now in our own lives, in our bodies, and our cultures, and our communities, and our countries, and in the international system. (Julia)
>
> "And that's what we're trying to do. So we don't leave it, you know, I've never left it at, "Oh well, you know, you have all these problems. Too bad. You just, you know, suck it up. No, what I say, "You have all these problems. Where did they come from?" You

know, “What does it mean? How did they manifest?” So whether it's about suicide, neglect, or violence, so those are the things that are the manifestation of, of previous trauma. And it might not be your trauma, right? That hurt people hurt people saying. So, you know, getting people, first of all, we have to get people to understand. (Wendy)

So, in all of my work, it's to raise that awareness about our past trauma. … And so I think it's about helping people realize and making people aware that if we haven't resolved our past trauma, then it's very difficult to work on the present trauma. And also that the present trauma it's around the triggers. The present triggers, triggers the past. So it's trying to help them make those connections. (Zora)

Emma believed that symptoms cast a light on what happened to people and communities in the past. “I think it was Richard Mollica from Harvard University that introduced me to the three words, symptom is history. I love that. So, when I see the symptoms, I'm wanting to map that with the community history.” Emma explained how she got community members, particularly youth, to engage with the history of their community and their country using expressive arts, such as painting or drama.

They all got together. They stayed up all night. And they painted a history as they would see it of Papua New Guinea from pre-contact before the Germans came in, before the British came in, how they lived then, and they named that there were some things that were not so good with the way that they engaged with each other culturally. And then, when the- the way colonization started to unfold, then the Second World War, what happened then. Then the timber getters coming in and the big international companies coming in to mine and to take timber. And it was on this massive canvas. And they brought it in and they asked if they could stand and talk to the whole group about this

history they had discovered in themselves as they sat up all night talking, talking, talking, and painting. It was brilliant.

Emma also drew attention to the poignancy of those moments when people start to draw the link between their present predicaments and the history of their community and ancestors.

> There was an older man, he was about 95 years of age. He was the great grandfather of the two boys who had suicided. And to welcome us there, he needed to show us where we could walk and not walk because it was also close to a ceremonial ground. And he was very gracious. But then, he then sat through the rest of the first couple of days just listening, just listening. And then he said, when things got really painful, "You can't stop them, you know? We couldn't stop the White men with their guns when they came in, so we can't stop our young people from doing what they're doing now." And that took my breath away because it was so clear that he was making the relationship between the powerlessness they felt when the horses and the guns came in and shot people to the powerlessness he was feeling now.

Similarly, Zora talked about the women's reactions after attending an exhibition that was organized in partnership with a local museum in Cape Town.

> And so for our Women's Day here, I took the women from the church, I took them to visit, to see this exhibition. And the response was just amazing in terms of- They started to connect with what these women had gone through with their own trauma and what they experienced. And whether it was emotional abuse, one or two of them, physical abuse.

Ezra argued that the purpose of revisiting history is not to undo the harms of the past because they cannot be undone. He wanted people to understand the traumagenic events that led

to the current state of play in communities, with the intent to interrupt the toxic patterns that perpetuate harm into the present.

> So that's the whole reason we do the archaeology, archaeological investigation. To understand the historical sources of the present-day harms. It's not to undo them. It's history. It's good to notice. What we're trying to do is stop the perpetuation, the continuing production of those limitations to their full flourishing.

Furthermore, Ezra argued that mapping the historical roots of present-day harms had nothing to do with assigning blame on some party or group for what happened in the past because it would make no difference to the goals of his interventions. He thus believed that restorative justice approaches are not suitable to address historical trauma.

> If we're committed to full flourishing now, we're only looking at that [history] to notice how we got here. It doesn't matter who is- It's not wrong. It's not right. It's not any of that kind of stuff, which is why I think restorative justice models don't necessarily work for historical harms because they ask, "Who's?" You know, "What harm was caused? Who's responsible for it?" It doesn't matter. It's interesting, it's fascinating to uncover the history, and to try and place and parse blame for who's responsible. <u>It absolutely makes no difference</u> [emphasis] going forward.

Several participants reported that the people are not always cognizant of their history and the influence it bears on their present-day life. Some referred to the educational component embedded within this empowering process.

> And that's an educational program to them, a process for them, because they don't know their own history a lot of the times. (Emma)

> And oftentimes people are like, "What, what does that [history] got to do with anything?" It's like, "Well, everything," you know [laughs]." (Wendy)
>
> They were not told about this history [slavery]. So they were not informed about this history. Only since post-apartheid, 1994, slowly this has started becoming part of education and, and the museums are starting to include it. … Often I think that there's, even among the Black community, I think with the people that I work with, and some of the communities, there's also that lack of awareness that it makes a difference, that it's important for my identity actually. (Zora)

Zora stated that she is somewhat wary of some of the work that is being done around forgiveness in South Africa, namely because of the lack of historical awareness in communities.

> I have to tell you that I'm a bit hesitant, with some of the work around forgiveness and that's been some of the focus because I kind of believe if people don't have an awareness about how they've been affected by the trauma, then it's very difficult for them to know what to forgive. And so I think that, that is kind of concerning.

Zora explained that she partnered with a local museum precisely to address the lack of historical awareness in communities. In collaboration with the curators, she started delivering programs to educate the public about the slavery heritage of Cape Town, while integrating her other work on historical trauma.

> So, I've actually partnered and collaborated with a museum here that works on slave narratives. And we've presented some programs. … And so we're going to be doing work with communities around raising that awareness on, not necessarily on historical trauma, but I include that work, but on their heritage.

Additionally, Zora expressed concern about how only a few social workers in South Africa are addressing historical trauma and the histories of the people in their work, especially because social justice is a core precepts in the social work profession.

> So, for me that was really interesting because if we are supposed to, if, if some of the principles for social workers are around social justice, around enabling communities, then, "Oh my God, how can we not be working with this?" you know. So, for me it's so essential and I feel that they've ignored the histories of people. And we work with what is in front of us only, what people present with.

She explained that social workers and social welfare organizations usually are caught up in responding to the crises that present in front of them and thus tend to overlook the link between the presenting problems and the history of the person(s) in front of them. "People tend to work with crisis and when the communities come to you, they're not coming to you about the, you know, the trauma that their great granddad experienced. They're coming to you about their present situation."

Framing Meaning Making Through the Lens of History

Some of the participants specified the need to help people realize how their own behavior and meaning making were also a byproduct of traumagenic historical events. This newly gained insight allows people to interrogate their behaviors and perceptions and their socialization process. Wendy drew attention to this point when she described an incident with a family that she was visiting following the death of a family member by suicide.

> People were sitting in, around the room in chairs. <u>Just sitting</u> [emphasis]. Like the chairs were around the room. <u>And not making a sound</u> [emphasis]. And I said, uh, "What's going on?" And they're like, you know, they were mourning and I'm like, "Why so

quietly like that?" [chuckles] And the, and the reason they told me, the reason for that was because the church had told them that it was shameful to cry and make noise. So they shut them down and not allow them to... Because they, before what they did was they did a, you know, rending of hair, like they tore their hair, and they moaned, and they did all that, right? You know, they cried and screamed. And they told them, "No, you can't do that." So can you imagine, you know, suicide after suicide, you know, trauma after trauma, and they have to sit there in a chair and bear it silently, and not even be able to share with the people.

For Ezra, it was important that the people acknowledged the perspective from which they were constructing meaning in their lives. He believed that individuals and groups "make meaning of observations based on historical narrative experience." By understanding the historical backdrop that informs their meaning making and behavior, they begin to realize that nothing in their social world is naturally occurring or immutable, which in turn opens up possibilities for change.

We understand the history as the source of the narrative. Because people need to have a sense, to understand the perspective from which they're making meaning of the world today. And so you don't want to ignore their history, but you only look at the history as the genesis. So when we talk about traumagenesis, we're really talking about the source of the trauma, which is the source of the narratives. … So we understand it, but we understand it so that we can see what came out of it, so that we can then notice that it's not a naturally, organically occurring. None of these systems are systems that occurred just on their own. They occurred in response to and in alliance with, in alignment with the narratives and discourse, and that came from somewhere.

Pablo claimed that “historical events [and] cultural events, they all become part of our way of experiencing things or expressing things.” Pablo helped representatives of conflictual groups become aware and gain insight into their respective chosen traumas, and to recognize how these deep-seated traumas were influencing present-day attitudes and behaviors toward disputed issues pertaining to current large-group conflicts. He explained how he became aware of the significance of chosen traumas while facilitating dialogue between Estonian and Russian representatives.

> Like when Estonians, after the second year or so, started openly to complain about Russians. The second guy in Duma was a member of these meetings, he started talking about the Mongol-Tartar invasion of Moscow or something. "Talk to me about psychological trauma,” and things like that. And suddenly, this is how I came up with a certain concept called chosen trauma. Sharing trauma becomes connected with your identity. Only to the Russians, the Mongol-Tartar invasion occurred. So they take it and they make it a marker of their identity. And if I humiliate your identity, you'll seek your marker. This is how I learned about the interconnection of actual historical trauma or your perception or shared perceptional trauma, and how internal roles get intertwined.

Pablo explained that when chosen traumas are reactivated, people experience a time collapse, whereby perceptions and emotions pertaining to a past collective trauma become fused with perceptions and emotions generated by the present conflict. Time collapse blurs the distinction between real and fantasized elements in the present conflict. Pablo helped representatives taking part in the discussions to experience a time expansion by allowing each party to talk about their respective chosen trauma, thus enabling them to separate the past from the present.

But mostly what I call, to have time expansion for them to have realistic discussions. When they, when they are discussing things and historical traumas come up, they have a time collapse. They are not moving, they are not moving, and we help them to separate all these things, the traumas.

Knowing History

All the participants demonstrated in-depth knowledge of the histories of the populations that they served and how those histories resonated in the present. They shared detailed accounts of the histories of the communities, which was an educational experience of sorts for me. This extensive knowledge is captured by the interview excerpts below.

Not a lot of the rest of the country know about this chapter of Inuit culture, even though they are an Indigenous people to Canada. But essentially how it played out was the Canadian government went down to Northern Quebec, where most Inuit peoples were from, and then took different families and relocated them up to these really remote outposts close to the Arctic, you know, the Northern Pole. So at the time, these Indigenous groups were told that they would only be there for two years, and it was a strategic maneuver before the Cold War so that Canada could have people in these places and say that they were occupied. So the motivation for that would be to deter Russian occupation. So it was effective, but the Canadian government went back on their word, did not re-relocate the Indigenous people back to northern Quebec area. And then there are other, other interactions before that. Things like missionaries coming over and introducing them to, to Christianity. (Johanna)

This is where the question of historic trauma comes in, the difference being that in Europe, the epidemic of the bubonic plagues hit on average every 40 years. So with the

time in between for people to reconstitute their cultures, and their languages, and their populations and, you know, get married and, you know, restart the economies, whereas on this continent, in, in the Americas, they hit on average every seven to 14 years. So there was no time to resolve or to address, or grieve. And they just had to keep moving. On the heels of the epidemics were the Indian wars, and then the removal policies, and then the, you know, the enfranchisement policies, and then the Indian Act, and then the residential schools, and then the missing and murdered Indigenous women, and then, you know, child welfare. So it's been a continuous impact. (Wendy)

Cape Town is on the tip of Africa. So it sits in the middle of the transatlantic and the Dutch Atlantic slave route. And it wasn't recognized through UNESCO as a heritage site for slavery because of how slaves happened to be there. So when you look at other places in North Africa, you see that they took slaves from those countries and they then exported them. What happened was that in Cape Town's situation, the slaves were brought there. Some were brought there by mistake, they were offloaded. Cape Town in the 1600s and 1700s, those centuries, it was a refreshing station. So what would happen is that the ships would come from the East, India, China, Indonesia, where they picked up the slaves. And they would go past the tip of Africa and stopped there to either offload all the sick or dead slaves. Or, and they would get refreshed as well, new food and, and all of that. Then they would load them on again or they would stay on the ship, and then they would go to the destination. So what had actually happened was that... So that's why the, the slave society of the Cape is really different. It's one of the most diversified society, slave societies. And so that is basically where some of the historians see how racial hierarchy started in South Africa, as well as the gender hierarchy in terms of the

amount of men in comparison to women, because slave men were always preferred. The male sex was preferred, which created, had huge implications for the society. (Zora)

In some cases, the participants enlisted the support of historians in the planning and facilitation of the interventions. Julia explained that having historians on the intervention team of the project that addressed the legacies of the institution of slavery helped illuminate those aspects of history that had been obscured.

And I think bringing in historians was really helpful in those particular spaces, right? There is the history that a lot of us don't learn, and then in order to start making sense of our own stories, like what I said before, we, we need to have some of that history that we haven't learned. … We had two historians actually come and speak in the beginning, after we had started getting to know each other.

Some participants highlighted the importance that mental health practitioners have a solid working knowledge of the history of the communities and groups they are serving.

And then the third piece, I would say, is really educating yourself on the historical piece. (Renata)

But I think that having a really good understanding of what happened in people's historic past is a really important part of this conversation. (Wendy)

Some participants suggested that mental health practitioners may have to rely on different sources to obtain historical information, such as reading literature from the cultures where their work is based.

I've been reading, you know, reading in South Africa, reading stuff from there, from all the stuff in Timor. I went through a phase, I just read everything on Timor. PNG, I've

been talking and reading from PNG, Tairora, but more particularly in Australia, I'm reading all the time. I'm also talking to people all the time. (Emma)

Simone remarked on her limited knowledge about the history of Indigenous peoples in Canada prior to enrolling in graduate school.

> You know, we heard stories about, how the Indians used live. That was the education we had. It's ahistorical. It's not current. It's, those people back then used to do this, this and this. And we didn't talk about residential schools. I had to go to a master's degree program in transcultural psychiatry before I heard about residential schools. That's pretty bad.

Similarly, Zora claimed that the history of the people of South Africa and the subject of historical trauma were not being covered in graduate training programs for social workers and psychologists, especially the history that predates the apartheid era.

> But in my profession, in my profession, in social work and even in psychology, there is very little mention of colonialism or slavery and the kind of, and the impact that it could possibly have on today. So, historical trauma doesn't really feature. The only person, in terms of in psychology and social work, who has started a discussion around historical trauma is, she's a professor also, Pumla Madikizela. She's from the TRC. But she focuses on apartheid narratives.

Kevin too expressed concern about the inadequate training of mental health professionals in Canada, who graduate from programs with little knowledge of the histories of Indigenous peoples.

> You can become any professional and have little, minimal, if not any training in the history of Indigenous people and colonization and the impact of Canada's history. So people again, will see people and they won't know how to relate. (Kevin)

A number of participants took it upon themselves to educate fellow behavioral health practitioner and other service providers such as teachers and police officers about the histories of the populations they served. They shared their knowledge of the histories of the communities and expertise on historical trauma in trainings and professional development events.

> I work with [name of organization], which does, which supplies teachers to remote communities so- And they're educated before they go into those communities, so that they understand historic trauma and they understand residential schools. They understand, you know, what young people are up against. Yeah. Like, why are these children they're teaching so, so traumatized. (Wendy)

> So, gender-based violence, that's the other focus area. So, I've done some training, but what I would help them start to look at, is look at what happened to Black women during slavery times. And aren't we seeing the same thing? So what hasn't changed and what has changed? I start to look at the humiliation then that Back men have experienced through apartheid. So, I make the connection with what happened to women in apartheid, what happened to women during slavery. And so isn't it time that we start to think a little bit about what are we talking about, patriarchy? How do we address that in our society? (Zora)

Zora explained how over the years she has learned how to integrate the history of the community or group and the concept of historical trauma in all the trainings that she delivers.

> I think what you sometimes have to do and which I've learned to negotiate it in that way, is address some of those issues but then link it to the past. So, I think, coming up and saying, "Oh, I've got this workshop on historical trauma," people, they're not going, you know, they're not going to want to buy into it. But if I connect it to the present circumstances of that organization or community, and I introduce the work, so I integrate it into our discussions and into the training.

Decolonizing Trauma and Healing

Another empowering process identified by the participants was decolonizing trauma and healing, which requires adopting a new outlook toward understanding and responding to trauma and healing. The participants used phrases such as “reframing trauma,” “re-conceptualizing trauma,” or “rethinking trauma.” “I think for me, it's also about rethinking trauma and how we understand trauma” (Zora). When discussing the need to decolonize trauma and healing, they made reference to different aspects of this process, including depathologizing trauma, promoting a broader understanding of trauma, enabling relational healing, and embracing culture-centered healing interventions.

Depathologizing trauma

Several participants drew attention to the fact that the entire field of traumatology is grounded in the Western medical tradition with its propensity to pathologize trauma and traumatic responses. Most participants expressed their wariness of this dominant paradigm and the mental health services that proceed from this model.

> I don't want to do it in an academic sense, of the way that academics kind of, I think pathologize quite often what's happening. I wanted to bring the stories in of the work that I'd done over the years. (Emma)

> We have to decolonize our mind because that's actually when we're doing therapy, we're decolonizing somebody else's mind, because of the pathologies and the deficits are imposed by things that weren't supposed to happen. (Kevin)
>
> One of the things that comes up a lot is that the models of health and mental health are still within these oppressive structures. (Renata)
>
> I was very weary of the pathology, that families in South Africa are always pathologized. And I think that social science hasn't been kind. And the way we've survived has been pathologized. And so for me there was more than just pathology to explain the reasons why people, why we've seen such high numbers of family and community violence. … So it's about addressing some of those things because what has been written on trauma and traumatology theory has been very Western. (Zora)

Zora further argued that the concept of trauma itself has its roots in the Western worldview. She explained that trauma as a term does not exist in any of the 11 official languages in South Africa, and so she seldom uses the words trauma and historical trauma in her work.

> So when I go into a community, I have to say when bad things happen to families, because they don't know the word trauma. And then I'll slowly introduce the word trauma. Also in many of our smaller cultural groups, the word doesn't appear in the language.

Additionally, all participants acknowledged that the physical, behavioral, and social manifestations of historical trauma are a natural response to overwhelming events and circumstances. They did not cast responses to trauma as pathological or as mental illness. They instead normalized responses to trauma through psychoeducation and the sharing of stories. By depathologizing trauma, the participants shifted the blame away from those affected by historical

trauma and began to undercut the stigma and the silencing that prevented people and communities from healing and moving forward.

> So it's about an experience or a set of conditions of overwhelm at some point in the past that people were either collectively as a society, as a neighborhood, as a, you know, as an identifiable group were unable to effectively respond. Not blaming them, but noticing resources and the level of overwhelm. And so it creates patterns of response that disinhibit their ability to fully, fully form in the present. (Ezra)

> But one of the things that is really important for the communities I work with to understand is that they're having a normal response to an abnormal and painful life and that they have tremendous resiliency. (Nathalie)

> People are now finally getting to the place where they're starting to understand that, that it's not about what's wrong with you, but what happened to you, you know, or what happened to your grandparents. Now people are understanding that we're more than just this, you know, person with depression. That there's a reason way behind that, that it may be a chemical imbalance, but it could also be other kinds of things that have been passed forward. (Wendy)

Several participants discussed the significance of helping people realize that most human beings experience psychological trauma in their lives. Some participants even ventured to say that “all humans are survivors of trauma” (Maya).

> The big overarching objective, like I would say is destigmatizing trauma, right? By acknowledging that it's a shared human experience of all, of all people on the planet, regardless of what caused the trauma. And therefore, if we all recognize that we're all

survivors, then we can break the stigma that it's just about those people who have experienced sexual abuse or rape. (Maya)

People are always responding to trauma. So, yeah. So, in other words, we can't, it's not fair to only look at the, in a sense, the pathology of trauma, but also to look and understand that people are responding to the stress, as I said. And they are finding new ways to do that. And some of it isn't necessarily pathological. Some of it is not necessarily- They are not necessarily experiencing post-traumatic stress. (Zora)

Wendy stated that framing trauma as a shared human experience when training mental health professionals and other service providers enabled her to open up the conversation on historical trauma to everyone and to sensitize non-Indigenous people to the plight of Indigenous communities by drawing on the common humanity.

Like, I tell these guys, "Ninety-seven percent of the population on this planet has had some form of trauma, and the other three percent are lying." [chuckles]. Everybody, right? So I draw them in that way. I don't talk about Indigenous people. I talk about how everyone- And I look out at the audience and I say, you know… "Some of you are hurting in this room [emphasis], and you don't have to put up your hand. I don't need to know who you are. I'm telling you, I know you're there." And I just talk to them about their, their experiences, their feelings, their knowledge of what hurt means. And then we talk about this, you know, "What are you seeing when you go into an Indigenous community? … I appeal to the people's humanity. And if you can't appeal to people's humanity, you're not going to get them to listen to you.

Several participants spoke to the need to help people "reframe their stories from the perspective of strength and courage" (Maya). For these participants, depathologizing trauma

meant uplifting the strengths and resilience of the people and communities while de-emphasizing trauma. Trauma-related behaviors were conceptualized through the lens of survival, attesting to the people's resilience in the midst of adversity. Most of the participants advocated shifting the focus of the conversation from trauma to resilience.

> And the more that we can do things in community that honor, that honor the gifts and wisdom that is already in us, it makes the job so much easier. It's really just about remembering than it is about trying to like do any kind of intervention, just like "Let's be together, remember our power and strength. Honor, honor and bear witness to the violence and the suffering. But then coming back to remembering our, our inherent power, strength and resilience. (Maya)

> I spend a lot more time with people talking about dependable strengths and what are the things that are going to keep you moving, the whole positive psychology. … So I think that's why, if we just focus on trauma, we miss out on that process of how people reconstitute themselves. (Kevin)

> To understand intellectually, you know, that you had a normal response to an abnormal life, and this is what happened. And that you truly are an incredibly resilient person. That even though what you're doing doesn't make sense, it makes sense in terms of what you did to survive. (Nathalie)

Maya and Renata pointed out that inasmuch as trauma is generationally passed down, resilience and wisdom are also generationally transferred.

> Healing is also generationally transferred. Resilience is also generationally transferred. And I think that often like that message gets forgotten or lost, because we just focus so

> much on, on generational trauma. But our ancestors survived to varying levels. You know what they went through and they passed that resilience down to us. (Maya)
>
> One of the things that really shifted for me was I was so focused on the historical, intergenerational trauma. And someone had pointed out to me like, well, when, if trauma is passed down, then resilience and wisdom is also passed down. So there can be a focus on healing the trauma as the center instead of uplifting the resilience and wisdom. And so one beautiful thing that was unexpected for me is how joyful this process was, you know, like so much color and food, and people coming together, and yes, to mourn and have closure. But also it was a good reminder that the resilience and wisdom needs to be lifted up as much as we're trying to heal the trauma. (Renata)

Promoting a Broader Understanding of Trauma

The participants helped people and communities gain a broader understanding of trauma that took into account the biological, mental, emotional, spiritual, and social impacts of trauma. Additionally, they acknowledged and shed light on the different mechanisms underlying the generational transmission of trauma, including epigenetic processes, adverse childhood experiences (ACEs), and cultural influences. None of the participants focused solely on the intrapsychic aspect of trauma; they were able to connect personal experiences of trauma to interpersonal and larger social processes and dynamics.

> And I think that's an important thing for us to understand that this pain gets transferred across. So, if I wanted to talk about trauma in relationship to a lot of the more recent research, and I want to make a point how it could be applied to our understanding in a community. So, we talk about epigenetics, we talk about cellular memory. … Sometimes we're embodied with the stories. It's in our cellular memory. (Emma)

> And then there is, you know, all the interesting research on epigenetics, which basically says that it comes through your epigenetic system as well. So physically it's being passed down. (Julia)
>
> And so the workshops are meant to give them a basic understanding around what is trauma, what are the symptoms, what is the impact physically, mentally, emotionally, socially, spiritually. And, you know, these are all things that they know already, but it's sort of validating to hear that, to hear what all the impacts are that, that they already experience themselves, even, you know. Because often the framework that, that we're seeing, the dominant Western mental health model really focuses a lot on sort of just like the, the mental and emotional. And, so we try to round out the understanding and experience to really acknowledge the somatic body impact, spiritual impact, and kind of the social-behavioral impact. (Maya)
>
> I talk about ACEs, you know, adverse childhood experiences, and the effects that the ACEs has. And I talk about, about epigenetics. (Wendy)

Some participants helped people realize how their behaviors had been shaped and conditioned by perennial trauma response patterns through their socialization process. These trauma response patterns have made their way into the culture, thus making it difficult for people and communities to distinguish between the two.

> And so we're not meaning making and developing fresh responses based on a clean slate. You're developing new responses inside of already shaped trauma responses, inside of already shaped trauma responses, and so the spiraling gets more intense. … Over time, people often begin to think that, they ascribe it to culture. They say it's our culture and so

they want to defend it. And it's cultural, but it's only cultural because it was a collective response to historically traumagenic circumstances. (Ezra)

We've been talking more about how we all enable it too, when we may not be aware, but by like, you know, normalizing these responses that then become culture. (Maya)

Historic trauma isn't just about what people tell you. It could be very much about how people behave around you. So what is culture, right? Is culture what people are doing right now? And if people around you are doing nothing but addict, addictions… You know, there's a, because we have serious addictions in some of our communities. If everybody you look at is high on something, then, you know, what is that? That is the culture [chuckles]. You know, it may not be what you wanted to be, but it is what it is. (Wendy)

Several participants mentioned the importance of educating people how unhealed trauma is manifested through acting in and acting out behaviors that continue to perpetuate interlocking cycles of violence and trauma.

If those guys couldn't fight the government, they couldn't fight the people who controlled the lakes, so they fought their partners, they fought their families, they beat their wives up. Then that starts a whole internal warfare. (Kevin)

Also as a big objective- To link together unhealed trauma with cycles of harm so that community members can see that, this like hurt people hurt people theme, and therefore see the urgency. How all of, how healing at the individual level can impact healing, you know, at the community level and beyond. (Maya)

> The point I'm making there, that violence that comes in, stays in. And it will be the despair, the rage, the anger, but it's turned inwards and then turned on those closest to us. (Emma)

Emma illustrated her of point of how violence remains in the system by making reference to an Indigenous community in Australia. Sexual violence experienced at a mission where several women in that community had been raised, in accordance with the government's removal policy of Aboriginal children, had penetrated into the families, which eventually led to many young people losing their lives to suicide.

> That the mothers were sexually abused, but they were silenced by it. They couldn't talk about it. So, when it moved into the family systems, that silencing continued.

Additionally, some participants drew attention to how unhealed trauma and cycles of violence play out at the institutional and society levels.

> The Americans, the Japanese, and the Australians fought on Papua New Guinea's soil. And again, the outcomes, when I go in to work there, I see the outcomes of that war and the violence that is now embedded in communities. (Emma)

> So colonialism is something that has had an enormous impact. So even though you don't have, you know, the British still physically in [name of country] as the ruling force or party, there are still internalized beliefs around folks from outside with lighter skin, knowing more, having more. And that is, I think that's an ongoing trauma. It's something that overwhelms. It's something that really makes people question, like their own capacities. … And it's being stuck in the, the cycle of victimization and violence, you know, whether that's direct violence or structural violence, or, you know, other forms of oppression and discrimination that come out of that. (Julia)

> I think that context is really important because then we can see how at the institutional level this plays out. When people act out of their amygdala, from this place of fear and fight, flight, and freeze, in their policy-making, that is just a re-enactment of the trauma response that also happens at the individual level. (Maya)

Maya further argued that institutional reform can happen only from the inside-out. Any attempts to repair and heal institutions are unsustainable in the long term unless the people who constitute those institutions have not embarked on their personal healing journey.

> There are articles out there that talk about the importance of changing at the institutional level, and I really don't know that institutional change is possible when, when there is lack of acknowledgement that like the individuals who make up the institutions have their own healing to do. It's sort of like inside-out versus like outside-in, and I am not sure that the outside-in is even possible. So we're trying to work from like, from the inside-out. You know, heal ourselves and heal, heal our communities and our institutions. … When it's just looking at the institution and not at the individual, I feel like what happens is like, it just flip flops between [chuckles] polar ends of the political spectrum. Because people are reacting out of fear to each other's policies.

Some participants pointed out that some of the traumatic response patterns and cycles of violence that they witnessed in people, communities, and societies had been around for centuries and could be traced back to the early colonial history of civilization. They seemed to believe that everyone is influenced to some extent by the legacy of colonization and colonial trauma.

> We all as humans on this planet have been impacted in some way by the colonizations that have happened over millennia. (Emma)

> I think part of the historical trauma of colonialism, I mean most of the folks who came here from Europe, they were actually colonized at some point, too [chuckles]. These are long patterns, right? They came here and did more colonizing. And so it's been integrated in the culture and I think this, the strong individualism has roots in trauma. Our inability to connect with each other and keeping our, ourselves and our stories and our emotions like separate from one another inhibits our ability to see how we actually are a fabric as a community. And it inhibits our ability to come together to resolve serious issues to move forward. (Julia)

> I mean it even traces back the White American response to, to violence, to the kind of medieval times of Europe and where violence was normalized and witnessing violence was normalized. And how over, you know, over one generation to the next, what that does to our nervous systems, our tolerance of violence, and normalizing violence as a response. Violence as a response to violence. (Maya)

A number of participants argued that because people are reacting in alignment with traumatic response patterns, they involuntarily become trapped in acting-in and acting-out cycles of violence. They also acknowledged many aggressors are survivors of trauma themselves and consequently they used their interventions to eliminate the arbitrary "good-bad binary" (Maya) separating survivors from perpetrators. Maya explained how she developed a program whereby perpetrators and survivors of domestic violence work on their healing alongside each other. She believed that stigmatizing aggressors and putting them in jail "is not gonna heal anyone."

> And so we talk about that now in our workshops, like we all have acting out responses and we all have acting in responses. And when we see, again like back to normalizing, when we kind of normalize, like "This is something that happens as a result of trauma."

So, you know, we don't need to, to blame, but we do want to hold ourselves and others accountable.

Enabling Relational Healing

Several participants emphasized the relational aspect of collective healing processes. They challenged the one-on-one therapeutic model assumed by Western-based trauma interventions. They argued that healing should not be limited to individual therapy because historical trauma embodies both an individual and a collective wound. They emphasized that healing is a relational process; it happens in relationship with others as people rediscover their connection with one another and start repairing social networks that were damaged by the trauma. The process of relational healing is evocatively captured in Maya's statement "We're really just kind of mirrors that are reflecting each other's and our own healing." There is healing "in being able to be with each other and express our sorrow, our humanity." The participants seemed to suggest that people heal better when they are together; they have more support and more energy than if they were walking the journey by themselves.

I think what I have learned very explicitly in Sierra Leone is how important it is to engage collective healing processes, and that's not to say that there's not a place to walk with individuals. … And, if you're being held in a larger container, there is extra energy, motivation, movement that helps you move forward in a way that you just couldn't have done on your own. (Julia)

And I just, I really think, and we talked about this before in our conversations that healing happens in community, and because historical trauma is, is collective, it's like that relational healing process is so important. And while I think there is a need for one-on-one healing tools, the biggest opportunity for healing historical trauma is when we do it

together in a circle, recognizing our own, you know, indigenous roots, cultures, customs that have been lost and colonized over the years, and acknowledging all the wisdom and strength and resilience. (Maya)

What we're doing is, we're doing this mental health system where instead of helping them repair and rebuild community, what we're doing is, number one, we're doing one-to-one care, which is- Just about every indigenous culture on this planet does family. (Nathalie)

So it seems like the community-based piece is huge. Like the one-on-one wouldn't work for this community. It has to be a community-based model. And some of these relationships last and so, you know, the protective factors, the social factors really help. That's one thing that people have told us. (Renata)

Even if you're not ready to emote, you can emote because they did, right? Like, maybe everybody starts to cry because one person's crying so hard and we all start to get emotional, right? <u>It's okay</u> [emphasis]. So those circles help other people. They help them move a little bit closer to the resolution process. (Wendy)

Disconnected trauma is when- Because we are made up of a social network, when we experience the trauma, the networks are damaged. All the networks end, in other words. So it's about restoring that. (Zora)

Both Maya and Simone indicated that relational healing is not restricted to the people participating in the intervention, but they too are part of that process.

So I want to be careful and not be using other people to do my own work. But a lot of my own healing happens in parallel with doing this community work. (Maya)

And at the end, and, you know, in a way I want to try to stand with them in solidarity because it makes me angry. It, it's not my family, but it makes me very angry, the things

> that I see happening in the news and the injustices that I see, that are going on, like, that I just see on a day-to-day basis. So, yeah, I mean, in, in a way it's, maybe there's a healing for me too, to be able to say, "Yeah, this is going on and this really sucks. And I'm sorry that this is happening." (Simone)

Julia argued that Western-based benchmarks of health and success tend to overlook the relational component of well-being and consequently disguise trauma.

> And I think that using kind of a different yardstick for health and success that we often see around us. I mean, there are clearly issues within our society around access to education, economics, and health care that, that need to change. But I think when our yardstick becomes access to money and higher education as if we're okay, I think that is incredibly problematic, right? And that totally masks trauma. Because if we're looking at, if we're using the yardstick of "Do we love ourselves?" "Do we really connect with others?" "Do we have solid relationships?" "Do we feel like we are contributing and making our community a better place?" "Do we feel like we see, we see our connection with the whole?" "Do we feel like we are actively contributing to that whole?" I think if we were using that yardstick to define healthy community, that would expose a lot more of the trauma that is experienced, you know, with all different people groups who have been on either side of the perpetrator or the other side of the victim.

Embracing Culture-Centered Trauma Healing

All the participants emphasized the need to deliver interventions that were culturally-appropriate and meaningful to the people and communities with whom they were working. Some participants adopted novel ways of being present with and support community members. Simone made herself available for casual conversation when working in Indigenous

communities, which she portrayed as a cultural-responsive gesture to connect with community members and offer informal support.

> And sometimes just being present and being available and seen in the community for casual conversation can be like a therapeutic way of offering, which is culturally respectful, but just offering a less formal, I guess, mode of support.

Simone also noted the importance of addressing spirituality when working in Indigenous communities. This realization prompted her to adapt her clinical practice to accommodate and welcome this dimension of well-being in the therapeutic process.

> Something that particularly Indigenous clients bring is spirit. And to do any kind of healing work without talking the language of spirit is just really, I don't think with, with this population, I don't think it's effective if you don't. And I, I don't think that, that it's really, really respecting kind of the roots of where the people are coming from so much.

Several participants drew upon the indigenous practices and wisdom of the cultural setting in which they were working and developed ways to integrate that knowledge into their interventions.

> So I think that has been where my interest has been most, is looking at Indigenous practices of collective healing, because I think they offer something that the West doesn't readily recognize and offer. And that's not to say that there can't be linkages, that there, there isn't value in the mental health system that has been created, but I think without acknowledging, I think especially the power of collective work, you can really miss something. Healing from historical trauma can't just happen with individuals in rooms [chuckles]. (Julia)

A number of participants addressed the importance of ceremony and rituals and wove these practices into their work. Other participants took part in Indigenous practices such as healing circles as a way to build on and enhance the effectiveness of their interventions.

> I think ritual is one of the most powerful things in working through historical trauma. That's actually another thing that I meant to mention in [name of project in the United States]. Well, certainly in [name of project in West Africa], there was ritual, there were bonfire ceremonies and cleansing ceremonies after the bonfire ceremonies that were very much drawing on cultural tradition. But, for example, in [name of project in the United States], we tried to find historically relevant places, you know, graveyards and churches and former plantations, to actually be in that space, and to recognize what happened there, to acknowledge ancestors. And I think there is, there is something that I can't, I can't really name, explain why, but it's just so powerful, about those kind of collective rituals in a significant place. And I feel like Indigenous leaders have vast experience with those kind of healing rituals. (Julia)

> I have the men develop a ceremony for the women to honor the women. I got the women to develop a ceremony to honor the men, and then I have both men and women to a ceremony to honor the youth. (Nathalie)

> I mean, it was done in a very community-oriented way, like we had a, a big procession in the community and then people were able to have a group ceremony to honor their loved ones when the bones were exhumed. (Renata)

> And so sometimes it's been about participating in healing circles that are by different people in the community, and sometimes I've been, had the honor of helping to kind of lead that process, whereby a group of people will, will speak in, in a round circle, usually

> one person is speaking at a time, maybe it's to do with an issue that's happened in the community, maybe it's about a death, maybe it's about a reconciliation of a fight between some members. Oftentimes it might have to do with, with a child or children being taken out of the care of parents because we still have that as, as a significant issue. And so, yeah, that can, that kind of intervention can almost be a bit like a group therapy, but, but its roots aren't, don't, don't really come from a Western psychotherapy model. You know, I mean, those practices have been around long since like my ancestors came here. And so, I really follow the lead and do what I can to hold some safety in the group as that process is happening. (Simone)

Simone explained that as a non-Indigenous therapist she was very mindful of not encroaching into a space that belonged to Indigenous healers and elders. She regularly consulted with and followed the lead of tribal leaders and elders to understand and determine what would be considered as culturally appropriate for the community members.

> I'm not Indigenous and I am not trained in their way of, of healing and being, although I have done some trainings. But I know that it's not my place to be leading those interventions, but I definitely try to make room for them and respect for them to come into the, into the space. And I try to seek out consultation with people that do know, with elders with knowledge and things like that, right. So they can even kind of guide me in what might be appropriate. Yeah, so it's a fine line, right. It's a tricky line because I don't want to overstep and step into a place that's not mine, that belongs to the elders.

All participants were intentional about their choice of therapeutic modalities to ensure that they were a good fit for the people with whom they were working. Some participants tried to adapt Western therapeutic approaches such as CBT, DBT, and REBT to make them relevant

to the understandings and worldviews of the cultural groups they were serving. Many adopted narrative approaches and used story maps, genograms, creation stories, and collective timelines to help people construct their personal and collective stories. Other blended in creative arts therapies and cultural-expressive arts such as drama, dance, and painting to facilitate story-telling and identify personal and collective challenges and issues.

> And we were doing story maps at this stage in the sand. (Emma)
>
> I'm trained in creative arts therapies, I'm often using art therapy, play therapy, sand tray therapy, sort of non-verbal ways of, of kind of expressing what might be going on without words, yeah. I've had, I can think of, not too long ago having had a family in and we were doing some family art therapy work together, which was quite profound. When you get the family to either, you know, draw on their own paper or then draw together on a big paper, that can be quite telling in terms of what's happening and where the healing and the movement needs to be. (Simone)
>
> And then I had them do sort of a modified genealogical exercise, you know, so they could look at, "Where did you come from?" "Who were the people in your, in your life, and how did you get here?" (Wendy)
>
> It's called a collective timeline. So, I do a collective timeline. I've done it with a few churches and a few organizations. And so I would deliberately start the timeline in the 1600s. And others would put present and so then I'd add different elements to it. So, we'd bring in apartheid and events around that. But I'd help them make those connections with their past and their present. (Zora)

Emma developed a new method for facilitating trauma healing in Aboriginal communities, which she coined “indigenist healing approach.” She explained that the indigenist

healing approach “was about art, music, theater, dance. It was story. It was the narrative approach. I call it stories. And that comes out of Lewis Mehl-Madrona's work.” This approach was inspired by a series of workshops that she delivered in collaboration with a group of Indigenous people as part of her doctoral degree.

> The group I was working with, my, you know, reference group, people who were giving me information and working with me in the community came to me and said, "We don't want to do this any longer. We don't want to talk about the violence any longer. We want to do healing." And I kind of threw my hands up and said, "What's healing?" And they said, "We don't know, but we want to do it." For five years- I took seven years to do my PhD, because for five years, I just did healing work with them. They would give me a title, you know, "Let's talk about family violence. Let's talk about what's happening with children. Let's talk about what's happening with our young men and young women. Let's talk about loss and grief." They'd give me a title, and then I would put a workshop together and we would run it. And so, the indigenist healing practice didn't come from any Western style therapy, counseling, it came from learning from those groups.

Ezra started his community interventions by inviting community members to watch and analyze a play or a movie that presented a problem story that contained conflicts and dilemmas with no straightforward path for resolution. This component of the intervention is intended to help participants contemplate their life and community stories depending on their own personal history and cultural context. Ezra explained that focusing on a movie or play prior to addressing the problematic in the people’s lives helped create some distance and objectivity, thereby enabling a clearer perspective on the here-and-now.

The first part, the first round is they look together at a play or a small movie or something like this. And they are, they're practicing, and what you say to them is, "If you look at this movie or if you look at this play, there's conflict in the play. There are problems in the play. If we say that the people aren't the problem. The problem is the problem. How do you name the problems? How do you name the problematic in the play?"

Some participants made use of somatic-based and tactile modalities to help people regulate their physiological response to the trauma and grapple with difficult emotions.

And then we offer different kinds of tools, mainly somatic-based, mainly cultural expressive arts-based, mindfulness-based tools to- A lot of it is about working with the nervous system and understanding the importance of working at that level. So not just like [giggles] not just through talk therapy. It's offering an alternative to CBT. And, and then we try to make the workshops as experiential as possible so that they can both, not just learn the tools kind of through their thinking brain, but experience them too. (Maya)

So, their shame and their powerlessness was exhibited in them laughing and joking. What I did to break that was say, "Oh, I think what we should do is all stand up, and each of us individually should use our body to express a feeling. We don't speak. We just express a feeling in our body." So, we did that. And, and then I asked them if they would all then, to finish off, write their name with their belly button. … So, it may sound silly to do an exercise, we've got to write our name with our belly button. And we all look crazy when we do that. But it also addresses the shame that we have embodied in our bodies that are there within our bodies. And we laugh. We laugh at ourselves and we laugh at the others while we're doing something like that. (Emma)

I'm trained in somatic experiencing trauma therapy, which I think is a really gentle, embodied way of talking and working through what, what is coming up for the client. And then what I like about that frame is it's, it's open enough, like it's got no structure, but it's open enough to allow for whatever the client brings. (Simone)

Many participants expressed skepticism about well-established Western-based interventions. They complained that culture-centered approaches to healing are generally not recognized as relevant because they do not fit in the dominant medical model. Because these approaches were oftentimes dismissed, securing access to funding to deliver or research this type of interventions was extremely difficult if not impossible.

And one of those challenges is that the rate we jump up and down thinking about, you know, that CBT is just fabulous. It's only just fabulous because they've done the research. <u>But there's a lot of other things that really work</u> [emphasis]. And I've been, I've seen them in North America, both in Canada and the U.S. Beautiful stuff. But it's not recognized as relevant. … So, you keep getting something pushed at you, when we need research that shows this stuff works. Why does it work? How does it work? And it's not CBT. (Emma)

The types of frameworks that are out there, and not really fitting within the cultural context that they're doing the work. So it might be like, basically too kind of White Western, you know, the model. And perpetuating more harm than healing it. (Maya)

Maya argued that the evaluation piece can be also problematic because the impact of this work cannot be neatly assessed using traditional methods of evaluation.

One of the glaring challenges is just like, it is very difficult to get funding for this work. … It's considered mental health work and therefore it gets put into a small corner, where

> only a few funders are willing to invest in mental health work. And then when it is in that corner, then... Then all of the kind of screening tools, metrics that are [chuckles], that are standard among mental health programs, also get attached to the work, which make it really difficult to [pause], to measure the true impact of what's going on, because those tools don't really measure. So like, that's another thing. It's just like the measurement, the measurement tools. (Maya)

Mobilizing and Building Capacity

A key element in most interventions delivered by the participants was helping clients, communities, and groups mobilize resources and build on their skills capacity. This empowering process hinged on identifying choices and possibilities, honoring Indigenous roots and resources, skills building, and rallying the support of allies.

Identifying Options and Possibilities

An important aspect of mobilizing capacity is enabling people to recognize that they have a choice of how to make meaning of and respond to their current challenges. The participants noted the importance of helping people realize that they can make different choices by helping them identify options and possibilities that better reflect what they want for themselves and their communities. Encouragement is essential in this process and they relentlessly motivated clients and groups to identify and consider alternative options and possibilities.

> Then oftentimes it's, it's working at sort of a level of getting them to generate some other options about how to manage that pain a little bit different, in a way that they're not harming themselves or putting their safety or their kids' safety at risk. So, and that isn't that hard to do because there is actually a lot of health and wellness and healing in

> Indigenous communities. So it's actually not that hard to kind of just refocus, re-shift a little bit. (Simone)
>
> So how do you move people away from that and, you know, and move them and help them understand that they're more than that, that there's more things that could be. So, you know, we ask people to look at, "What's happening around you right now?" "What do you want to keep and what do you want to change?" (Wendy)
>
> Talking about slavery and colonialism helps us to create new positions. And so the work of the narrative work is around that. (Zora)

When delivering school interventions in remote areas in Northwest Canada, Johanna sought to inspire children to think about their future and visualize educational and career opportunities that they might have not considered before.

> For children in particular, I want them to be, feel encouraged that they can use their imaginations, to visualize certain opportunities for themselves that may not exist right in front of them where they are, but still exist in the world and still can be created in their communities for them.

For Wendy, a major goal when she worked with youth was helping them look beyond the hopelessness that they were feeling in that moment and embrace the future with more optimism.

> Talking to young people, you know, and trying to help them understand why they're feeling the way they are, you know, when they feel like there's nothing beyond today. You know, like "I feel like s*** today and that's it. There's nothing beyond it." "Yes, actually, there's a lot beyond it. You know, you're gonna have lots of other days like this but it's not the end."

Another aspect of Wendy's work with young people was helping them understand that their lives were not doomed because of ACEs in their past or the history of their ancestors. She argued that it was important that they realized that they had other possibilities in front of them from which they could choose.

> Because we tell them, you know, it's just because like I have seven of 10 ACEs personally, but it doesn't mean that, you know, I'm lying in a gutter somewhere, you know, unable to function or do whatever I have to do in my life. And so we want people to understand that too, that, you know, that there's, there's your, everybody has it within them, you know, with assistance sometimes or sometimes just sheer force of will, to do something different with their life. You don't have to be in a place where it's all, it's all that. There's all kinds of other ways of approaching this and having this conversation. People have choice.
>
> "It had nothing to do with you. And you are not your, you pull traits and experience and genes from your ancestors, but you don't necessarily repeat what they did." [chuckles] So that, and I think that's a big fear for a lot of people. There's, I mean, for young people, I guess, who haven't had the depth of living and experience to realize that they, that they have a choice. That they, they can do it differently, or that they're not- If it's a dark past, that, you know, that it doesn't mean that their life has to be dark as well, you know. And, and I think that, that's the really important part of what this work does, is it helps people look inward in a different kind of a way. (Wendy)

Ezra, on the other hand, invited people and communities to identify counter-narratives that were more supportive of everyone's well-being and full flourishing and that could counteract the dominant oppressive narrative.

> What else is happening that's not explained by that [dominant narrative]?" And they start telling you the good stuff. And you say… "It's perfect. So both of those narratives are happening in your community at the same time. Every behavior that you take is informed by or reinforces one or the other of those narratives. If you had a preference for how your community was known, would you, which would you prefer?" And then once they choose, and they always choose the one that's like, you know, this better, nicer when they choose, it's like so it's already there. It's not like it's not present. We're not making it up out of whole cloth. It's already there, but it's just not the dominant narrative.

Another strategy adopted by Ezra is encouraging people to select an alternative personal narrative that allows them greater freedom and agency in how they make meaning of events and experiences in their lives.

> “This is what I'm making it mean and in the way that I make it mean, it gives me either liberty or limitation on how I can respond." "Is there another story that somebody else can draw from or that you can draw from that you're aware of that gives you greater agency and ability to respond so that this doesn't remain a problem story?"

Emma relied on several declarations issued by the United Nations such as the Universal Declaration of Human Rights to educate communities about their fundamental rights, which enabled them to identify possible avenues for action.

> We actually pulled out the UN Declaration of the Rights of The Child. We started with the rights of the child on the first day. Then we did human rights and women's rights. And then we did Indigenous rights. And there was not a person who attended that workshop- I said I'd take 20 men and 20 women and whatever children turned up. There

was not a person who'd heard from their government, that their government had signed those declarations.

Honoring Indigenous Roots and Resources

Another approach that helped mobilize capacity was honoring indigenous roots and resources. Most of the participants encouraged people to connect to their cultural heritage and seek support from Indigenous service providers and other resources that already existed in their community setting. Helping people to celebrate their Indigenous roots and resources instilled a sense of cultural pride and emphasized cultural protective factors that promoted healing and growth.

Emma helped people and communities to celebrate their indigenous roots by using indigenist interventions that were based on age-old Aboriginal healing practices that had been pushed aside because of colonization.

I also then started to understand that in fact Aboriginal people had deep cultural processes that were healing. So, I started to research those old deep cultural processes that had been pushed aside. … And then we started to name this as indigenist healing practices and resurrect them because then that gave people a sense of pride in themselves.

Other participants encouraged people to participate in traditional ceremonies and activities as a form of support. In some cases, the participants were invited and took part in cultural ceremonies and rituals.

So I might get people to, you know, we might have some beads in the room that we're in, and they're showing me, they're teaching me about beading and, and their traditional beading crafts that they're doing, and we're talking through something that's going on. And then I'm encouraging them, "Well, why don't, why don't you, what if you were to do

this beading work when that feeling of panic comes up for you instead of..." you know, this, that, the other thing that they might be doing. (Simone)

I've also been able to participate in potlatches and more traditional community interventions. (Simone)

Obviously, you know, in an Indigenous community we use the seven teachings. You know, we use, we use a number of different tools to help people. Ceremony is a very important part of that, like we, you know, actively encourage people to get into ceremony. I mean, some people will go to church. You know, whatever works for you works for me. (Wendy)

Simone and Johanna explained that, as much as possible, they tried to help clients connect to Indigenous knowledge holders and service providers as a way to validate and uplift those community resources.

Sometimes I might offer something, I might bring in a little DBT thing, or a little CBT thing, or a little cognitive therapy thing. But, if I can find something that is already in their community, if there's, you know, a knowledge holder, if there's even, there's a priest, let's say, at the local church that is trusted, then I might encourage them to start to reach out, make some contacts and connections that way. (Simone)

I rely on other service providers and [name of Indigenous group] counselors and Indigenous resources as much as possible. I really want to validate and, you know, just from my, my referring out to Indigenous services, I think that's really important. (Johanna)

Additionally, Johanna highlighted the achievements of Indigenous people who became successful despite tremendous challenges as a means to inspire children in her school interventions.

> So what I would do is I would go into schools and create these presentations, PowerPoints of all the [name of Indigenous group] who had succeeded at beating the odds, were able to avoid starvation, were able to avoid death, were able to obtain education despite the incredible barriers to any kind of quality education up there. And, and I would kind of try and shine light on these, these people and field questions.

A few participants tried to illuminate how communities had managed traumatic events for millennia prior to colonization and to revive and celebrate those coping practices.

> Part of that is to have learned from Indigenous peoples around the world, to hear how they managed before colonization. … We're actually going back to old therapeutical healing practices. And we're making them relevant to the healing work that needs to be done out of the colonization that has impacted on our people's countries. They're relevant today. (Emma)

> The interesting thing for me is that within our traditional Black communities and cultural groups, I've often said, in Africa we have always dealt with trauma and we have managed it within the community. There has never been this idea of putting people outside the community because they are suffering from whatever. It's been dealt with. (Zora)

Zora also used her partnership with the local museum to highlight the invaluable contributions of enslaved women and men to the city of Cape Town.

> Because they started to think about the contribution that these women had made to the wealth of Cape Town. And so, while it was traumatic, but it also gave them some sense of identity and some sense of belonging.

Facilitating Skills Development

Skills building was a central component of capacity building in individuals. Most of the interventions delivered by the mental health counselors and some of the other participants were designed to build on the people's skills so that they were more equipped to navigate the challenges in their lives and in their communities. Some of the skills mentioned by the participants were emotion regulation, mindfulness skills, decision-making skills, and somatic-based skills.

Johanna stated that her clinical interventions revolved around first stage trauma processing and resource building. Learned helplessness was a central theme in her work due to the high incidence of lateral violence, and consequently, she sought to empower clients through skills and resource building.

> The phenomenon of learned helplessness comes up a great deal in my work. I have to do a lot of empowerment and encouragement to build on those skills because the incidence of lateral violence in these communities is so high.

Johanna employed a multimodal approach in her practice. She used DBT to promote emotional regulation, distress tolerance, core mindfulness, and interpersonal effectiveness. Additionally, she applied emotion-focused therapy to facilitate emotional release and help clients gain greater awareness of emotions, and EMDR to process childhood trauma.

> So, like I use- Dialectical behavior therapy is great for the structure and for the skills building, specifically in emotion regulation, core mindfulness skills, and being able to

> articulate and to differentiate, you know, when to say certain things for what. And then other times I do emotion-focused therapy just to get out the emotions. And then the third is EMDR. EMDR is really great if they're in a safe place now, there's no immediate danger, then we can do some, some historical trauma processing.

Johanna applied psychoeducation to educate clients on how to make safer choices and decisions by helping them distinguish between healthy versus abusive relationship patterns.

> And with intergenerational trauma, you're going to retraumatize without additional supports. So when I meet with them individually, um, it's just to, to validate and to help them distinguish between what's healthy, what's unhealthy in their family, what's abusive, what's non-abusive in their family, the psychoeducation surrounding that.

Simone prioritized safety and stabilization in her clinical interventions. Simone, like Johanna, used DBT to equip clients with skills and strategies to effectively cope with and regulate their emotions. She also used somatic experiencing trauma therapy to help clients become more attuned to their physiological responses to trauma and to increase their capacity to handle the symptoms of stress and trauma through self-regulation of the nervous system.

> And then the other thing, another one might be just, you know, the old emotional regulation is kind of the charm we use, to get them eventually over time and start to tune in to what's happening in their bodies, recognize it, have some names for the different sensations, and then have some of those tools available to be able to down-regulate when they need a little bit.

Simone argued that safety was a major goal in her interventions and she often adopted a harm-reduction approach to assist clients in replacing harmful coping behaviors with safer or less risky ways of coping.

> So oftentimes I'm just working more from a harm reduction kind of level. So just trying to, you know, if they're coming in about suicidal ideation, or they're coming in about some self-harming behaviors or just, usually trauma, anxiety, you know, that kind of thing, maybe a relationship break up is what brought them in, but there might be lots of substance use going on as well. … So sometimes it's, it's about substituting sort of one coping for another coping, and getting things to a level where they're a little bit safer. That's often kind of what's, what's going on.

Maya facilitated workshops to train local leaders and front-line workers who were supporting community members and families affected by the impacts of historical trauma. Her workshops consisted of basic psychoeducation on trauma awareness and an experiential component that exposed participants to different tools that they could use to support trauma survivors during crisis situations and over the long-term. For the experiential part, Maya used somatic-based, mindfulness-based, and cultural and expressive arts-based techniques.

> We train in basic tools that they can use to support survivors, both in a moment of crisis and over the long-term to help- So in a moment of crisis means they're getting basic skills and emotional first aid. And some like listening skills, but also different tools to be able to support survivors to regulate their nervous systems over the long-term. And that's a lot of this somatic body-based skills.

Nathalie invited community members to join the intervention team to ensure that they left the necessary skills and resources with the community after they left.

> Whenever we go into a community, we ensure that members of that community are on our team. So they are learning from us as we're doing it, so that when we leave, we leave the skills and we leave the support with the community when we leave.

Rallying Allies

Another approach to helping clients and communities build capacity was rallying the support of allies. Several participants highlighted the importance of helping people identify and connect to social supports in their communities. Some participants also argued that they could not do this work without the collaboration and support of other professionals or allies.

In some cases, the participants encouraged the people to reach out to other members in their community.

> So, you know, getting people to work together, to collaborate with each other. To realize that, you know, as individuals, they are not the ones that are going to solve all the problems. (Wendy)

Renata and other team members supported the youth who took part in their project in Rwanda to reach out and coordinate with education officials if they wanted to have the intervention at their schools. They also encouraged them to rally the support of authority figures in their community.

> We actually didn't go through like higher levels of the school directly. So the youth were in charge of their project. And so, for example, if someone wanted to do a project in their school, it'd be their role to talk to those. So really, our only connection was through the youth themselves. And then supporting them if, you know, if they needed letters or whatever. But it was more of, like we were connected to the youth and the youth would contact their systems rather than us going to the Ministry of Education and then trying to contact the youth.

When working with children, Simone invited the support of central figures in the children's lives, such as parents, teachers, and social workers.

So a lot of the work I find is not just with the clients, but with their permission and their consent, working with the people who are around them to support a team. These would be the ones like the little kids that are really at, at, you know, extreme risk. Then you would wanna be working maybe with teacher, social worker, parents, families, for sure, maybe grandparents.

Several participants relied on the support of Indigenous elders, leaders, and service providers to deliver the interventions and to ensure that the work that they started in the communities was continued. In some cases, the community members who reached out for assistance from the participants became the allies. The participants valued these relationships and saw them as being integral to the success of their work. They were also eager to continue building their network of allies.

School teachers are my collaborators. They ring me up and say, "[Name of participants], we've got some kids here that really need some help. Can you help me?" And I say, "Yep, we'll come out. I'll tell you what I'll do, I'll do a workshop for your school. And then we'll work out how we can apply some of those things in there for the school." … Doctors can be my collaborators in a way because they might ring up and talk to me about the, the rates of sexually transmitted diseases in children. (Emma)

I use space when I'm in [name of territory] communities from the health center. So often I kind of partner with mental health nurses. If I'm fortunate, there's a permanent or indeterminate, as they call it, a health nurse, a mental health nurse working there. And then I do a mixture of debriefing, case consultation, processing, yeah, and case management collaboratively with them. (Johanna)

> I just moved back, I just moved back at the end of October, so I have to get out there and I really want to build relationships with the healers out there. (Johanna)
>
> Definitely wise elders that themselves have been following a healing path and are connected to spirit or connected to culture, connected to their healthy, healthiest self, or healthy parts of themselves, I guess. They would be the ones that I would want to connect with the most. Sometimes it can be helpful to connect with people that are a bit more like the chief or people that have more of a political ownership. Sometimes that can be useful. If there is like an Indigenous support worker or an Indigenous social worker in that community, that's often a really important person to work with because they might be, they're in, embedded within the community, so they may have a better gauge as far as, you know, if something is, if the situation is looking unsafe to me or I'm not sure what might be happening. Sometimes talking to that person could be helpful because they might have a perspective on what's happening that is different than mine. (Simone)

Pablo worked within an interdisciplinary team that helped him facilitate dialogue between representatives of rival groups. Pablo's team included psychiatrists, psychologists, diplomats, historians, linguists, and lawyers.

> And after I finished that for five years, I decided that I will open a center at my university, the [name of university], called the [name of center]. I had psychiatrists, I had psychologists, I had high-level former diplomats, I had historians. … I had lawyers, I had linguists. Oh yeah, it's interdisciplinary.

Zora developed a partnership with the curators of a local museum to raise public awareness about the slavery heritage of Cape Town and its relationship to historical trauma. She

also collaborated with the Dulwich Centre which uses narrative approaches to respond to community mental health challenges and collective trauma in Australia and many other countries.

> So, I've actually partnered and collaborated with a museum here that works on slave narratives. And we've presented some programs. And I like the work of the Dulwich Centre, which is a narrative community. They have the journal, the International Journal of Narrative Therapy and Community Work, and they're based in Australia. And so they do a lot of work with traumatized communities around the world. And, and so I've collaborated with them.

Ezra's interventions were designed to rally the support of individuals who identified with the dominant culture but were committed to overturning the status quo and advocate for social and political transformations to redress and end the plight of historically disenfranchised groups. He explained that his approach of rallying allies from other side of the tracks was met with resistance by social activists and organizers who found it difficult to transcend the "us-them" binary.

> We got to build a table big enough for those who are, whose identity isn't or don't believe that their identity is, because they probably is but they don't believe or they don't necessarily want to. They're not committed to their identity being based in superiority. … Like right now you're just trying to take, you're just trying to get power from those who are victimized and, and only know themselves from a victim perspective. It's not a great pool to draw from as we're trying to- We need some allies. We need some folks who don't understand themselves as victims, and recognize that the systems are set up for their success but are willing to do something about it. Let's get them to the table, too.

Now, with that group, if we need to, if we're trying to change structures, we've got a much better base from which to move, to shift structures.

Wendy and Zora relied on their extensive professional connections to enlist the support of allies. Both practitioners had developed a strong network of allies that included professional organizations and high-level government officials.

I've been doing it for so long that I just, they're just there, like I know people. I mean, I sit on a number of different boards. You know, as a faculty at the [name of institution], so that's people coming from all around the world. You know, there's, you know, I work with the Minister of Indigenous Affairs quite closely and have for the last, you know, over a decade. You know, we have a senator that's in our sort of region. We do reconciliation work in circles together. And I make myself available too. You know, like a lot of the churches in the territory will call and say, you know, "We've got three churches here and we've decided to band together. We'd like you to come and speak to us about, you know, history or about reconciliation or about child welfare." … And so having the capacity to have all those different levels of interaction. (Wendy)

So with social workers and community organizations and government as well, so in terms of, particularly around gender violence, but I've also been busy with and in the middle of doing training on gangs for our specialist unit, works with gangs in Cape Town, or in South Africa. (Zora)

So the university as well I think makes it possible. But also I think my own connections. I think that in terms of, because of my social work role, we're very good at networking and that's very big. I think in South Africa our resources are so limited, so you have to make connections and know everybody in the community. (Zora)

Translating Awareness, Knowledge, and Skills into Action

A sixth empowering process that was identified by the participants is helping people translate their renewed awareness and knowledge into concrete behaviors and actions that bring about meaningful changes at the personal and collective levels. The participants seemed to suggest that gaining awareness, knowledge, and skills was not enough; these behavioral components had to be followed by action. "This whole question of helping people understand what is the contemporary manifestation of historic trauma and how do we actually address it is very different" (Wendy). The participants shared several examples to illustrate how people took action at both the personal and the collective levels. The central question at the heart of this empowering process is "How do we not carry it [historical trauma] into the future?" (Wendy)

Acting at the Personal Level

The participants did not stop at helping people make meaning of the challenges they were facing in their lives and in their communities; they also encouraged them to take responsibility for their behaviors and to engage in actions that lined up with what they wanted in their personal lives.

> When somebody says, "This is," it's like "Stop that. It's not is. This is what I'm making it mean. This is what I'm seeing. This is how-" And if you do that, then you realize that you're contributing to the reality. It's not that it's the reality. It's that, this is how I'm taking these observations and constructing them for my life, which is perfect. It's not the "is." It's never is. It's, this is what you made it mean. And now what, right? (Ezra)
>
> But we do want to hold ourselves and others accountable. We are all accountable for both examining our own acting out and acting in responses and, you know, where we can

make the change. And then educating others about that, too, so that they can also make those changes. (Maya)

So how do you move people away from that and, you know, and move them and help them understand that they're more than that, that there's more things that could be. So, you know, we ask people to look at, "What's happening around you right now?" "What do you want to keep and what do you want to change?" You know, "What do you, when you move forward in your, in your life or your community's life, what should be there? You want to do a better job with your children, "What do you need to do?" You know, "What kinds of responsibilities does that mean that you'd have to uptake to get to that, get to that place?" So I spend a lot of time working with people, helping them, because it's always a question of what do I do? (Wendy)

Wendy encouraged the people, especially youth, to choose the path get them closer to their healing.

But I guess the, you know, the sort of the bottom line is, you know, get yourself around good people. You know, like find, you know, go to a place where people are uplifting, you know, where you can spend time having good times. … Find the thing that will send you healing. Allow it to come into your life. (Wendy)

Wendy believed that people who took it upon themselves to take control of their lives and engage in action were able to cope better with adversity and the legacy effects of historical trauma.

You know, I mean, if there's a flood, everybody's affected by it, but everybody's affected very differently. You know, I explain that to people, that some- I mean, action is, is important. If, you know, if you looked at it on a continuum, people who are affected by,

by residential schools, the people who were very passive and couldn't fight back and, you know, just took it. And the ones that said, "I'm out of here." [chuckles], and either left or ran away, you know, took action are generationally better off than the ones who just took it because they took action. So, you know, explaining it to people, so they understand, "So you could take action now [emphasis]." You know, you can start to learn about it. You can read about it. You can talk about it.

Some participants talked about personal-level changes and outcomes that they witnessed in the individuals and families who took part in their community interventions. Most of the outcomes revolved around increased personal and interpersonal safety.

In those particular family groups, have there been any more suicides? No. Two things, they're dealing with the truth. And secondly, they've got active in, in working to prevent anything happening further. So, they've got a strength in them now to stand up and do good work. (Emma)

So they're small in terms of outcomes, I mean, they don't sound very grand, but it's really to, to increase safety. (Simone)

Simone stated that although finding safety may sound like a basic objective, it tends to be a far more difficult task to accomplish for clients who have never known safety in their lives.

That is usually the place where I'm working and I'm just tending because, because we're talking about a level of, like it's very different than a single incident PTSD, where somebody's nervous system has, has grown up in safety as a wee person and they've developed into an adult body where they can hold a job down and have, you know, a good quality of life, and generally some relationships going that are healthy, then they have a traumatic experience. But the baseline that they're working from has a certain

> level of, of health to it. This is not that. This might be work with people or a group of people who have never found a lot of safety. To think that you're gonna go back to somewhere that they haven't been before is not, you know, may not work.

Acting at the Collective Level

Participants reported that in some cases, the people applied their new awareness, knowledge, and skills to promote action at the collective level. They became change agents in their communities and societies.

Emma noted how community members participating in two separate interventions translated their new awareness and knowledge into action at the collective level.

> In the first one, it was the father and the mother who then decided they would work in the area of domestic violence or family violence to show people how harmful it could be to the young men. And it was their young men, their two boys that chose to take their lives. In the second workshop, one of the mothers, when she heard this come out about the sexual abuse, she was quite angry, and she wanted to know who did it. She wanted to get moving on it straight away. And we all decided that we would keep doing the workshop and we would support all the moms of all the girls to work through whatever. And she now is an excellent worker in the area of child sex harm.

In another intervention in Papua New Guinea, the people who took part in the intervention experienced a greater sense of agency and they started demanding social and political transformations from their governments and institutions.

> And so what they're saying to their government, "We want this. We want the police to be doing this. We want the Health Department to be doing this. We want our children to be taught our history, not somebody else's history, but our history in this country. We want

the Department of Environment to stop the timber getters coming in or the mining companies coming in from overseas and damaging our country."

Ezra stated that the goal of his interventions in communities was to “stop the perpetuation, the continuing production of those limitations to their full flourishing.” He encouraged community representatives to think of what they needed to do to start shifting the narrative and promote their preferred narrative.

> And so the narratives that we live in are reinforced by the choices that we make and the choices have just become habitual. What do we have to do to change the habit so that this other narrative is more likely to be the dominant narrative? That's the work.

He also encouraged the people to recreate the systems and structures in ways that increased the likelihood of everyone’s full flourishing.

> What changes in relationships, resource distribution, structure, and testimonial authority would you need in order for this to become the primary habit that people understood about your community?" And that becomes the basis for the social action agenda that changes... And so it's in those other things that we begin to shift the narrative. And we shift the narrative by changing relationships, resources, structures, levels of testimonial authority in support of this other primary narrative. The other thing still exists. It will, it will exist for years. And it just gets diminished in its importance and its significance as we build a habit of being in this other relationship.

Ezra emphasized that nothing productive comes out of blaming other people for the problem. The goal instead was shifting the problematic narrative by changing systems and structures.

> Everybody is to blame. "Let's stop that. Okay, people aren't the problem." Why do, why do I say that? Because, because as soon as you say people are the problem, then whoever

has the power is going to determine which people get to continue to exist. That's not, that's not, you know, that, that is not the path that we want to go down. Because if you say "These people should be eliminated," they're going to say, "People like you should be eliminated. That's how we solve the problem." That's not helpful. That's not healthy at all.

The goal of Pablo's interventions was to achieve peaceful resolution of current conflicts and de-escalation of geopolitical tensions. He explained how in several ex-Soviet Union countries, the objective was to facilitate a peaceful transition to independence. He recounted how in Estonia, following a heated dispute over a stretch of land that the Estonians agreed to concede to the Russians, an Estonian representative made it his mission to go to the border towns to ensure everyone safety.

He himself, personally went to all the border towns and helped people to find more peaceful solutions? I mean, so what we did in Estonia, Latvia, and Lithuania, without any bloodshed, is people became independent.

Julia noted that her intervention in West Africa had elements of community development embedded within it. She argued that that trauma healing and community development are interrelated processes, although they are usually depicted as distinct activities that have to be approached in a certain sequence.

But it's also a collective process and discernment around how the community wants to develop moving forward. So one thing that we have learned is, like on a real day-to-day basis, you can't actually separate those two things, right? Because somebody's individual well-being, their relationship with somebody else is also very connected with their livelihood, right? It's not like mental health is a separate thing. … So that's, I think, have

been another learning in the collective process. They can't put mental health and interpersonal healing like in a box [laughs]. … And when you look at places that, where there are significant social problems and people are not able to come together to identify what their priorities are, um, a lot of that is because of the ruptures, um in the community between people, um, and within individuals, right? So that's, that's also a motivation. Like, "Okay, we have to face this. We have to heal because we want to move forward together." (Julia)

Johanna and Simone, too, saw this connection and expressed interest in getting involved in community development work.

I would love to form an alliance, a kind of a cohort to consult with the leaders and community to do community development work and to harmonize Indigenous services with non-Indigenous services. (Johanna)

The first thing is community development work led by the community itself. So it, it's not... You know, I think people sometimes think, "Oh, let's just shoot some money at the problem. No, I don't think that's really it. I think that it has to come from the community itself. It has to be very respectful and it has to be a, sort of approaching folks in a very humble way and saying, "Is there anything I could do to be of service?" And, "What are your needs?" Like approaching the leaders of the communities, "What are the needs here? And what do you think would be helpful?" … So really carefully, mindfully collaborated with the people that are there, to say are the authority, I think, on what they need. (Simone)

Some participants used what they learned in their work to advocate on behalf of the people and the communities whom they served through academic and scholarly endeavors and through systems and social advocacy.

> I think that at the beginning of my career, I was really cautious. And I still am cautious around the advocacy piece because the role of a therapist is quite precise, and if anything, it's a bit restrictive. I mean, it's, confidentiality is crucial, right? And if you don't have that, like, then that's the crux of it. So I think that I, I feel a little cautious around what kind of advocacy, in what context. But yes, more and more, as in growing up [chuckles], and kind of thinking there are ways I can do advocacy within the system that don't maybe put the confidentiality with the communities at risk, for example. So, like I went back to doctoral studies precisely to do research in this area, because we don't really have much research. And I think that is a piece in and of itself of advocating for those communities to get that, kind of, down on paper and start to document some of the people's experiences. I think it is, is a way of advocating and trying to move towards change. (Simone)

> But I said to him, you know, "You should allow the people in the community or the ones that come to the community during a suicide, to have a conversation about this in church. They should be able to talk about the loss of their sons and daughters." And he said, "No. No. They will get upset." And I said, "Of course." I said, "Of course, they're gonna get upset. They, they, they've lost a child." And he said, "No, I don't want that." So he said no. So then, you know, I sweet talked him about it a little bit more. And in church, he allowed it. So people were coming up to the front and talking about the loss of their sons, and they were crying, and, uh, and everybody was crying. Everybody was crying in the

church because it was so emotional. And then, and then when I left the church and went home, I was walking... So, you know, it's kind of a long road down. I was walking along the road and he pulled up in the truck, and he said to me, "You see, you see what happened?" And I said, "What happened? Like people cried." [increase in pitch] And he's like, you know, "Well, you know, we don't want that." And I'm like, "They have to cry to heal. They have to be able to say something about how they feel to be able to heal." (Wendy)

The participants' interview data is mapped against the conceptual categories and focused codes in Table 2. The relationship between the different conceptual categories and the final theoretical model are examined next.

Table 2

Participant Mapping of Conceptual Categories and Focused Codes

	Emma	Ezra	Johanna	Julia	Kevin	Maya	Nathalie	Pablo	Renata	Simone	Wendy	Zora
Holding the Space												
Laying the Foundations		X		X		X	X	X	X		X	
Allowing the People to Lead the Process	X	X	X	X	X	X	X	X	X	X	X	X
Nurturing Trust	X	X	X	X	X	X	X	X	X	X	X	X
Establishing Safety	X	X	X	X	X	X	X	X	X	X	X	X
Attending to Personal Needs	X		X			X	X		X	X		X
Naming the Problematic												
Owning Your Story	X	X	X	X	X	X	X	X	X	X	X	X
Uncovering Underlying Patterns Defining the Story	X	X		X	X			X			X	X
Assuming a Systemic Understanding of the Problematic	X	X	X	X	X	X	X	X	X	X	X	X
Revisiting History												
Mapping the Historical Roots of Present-Day Harms	X	X	X	X	X	X	X	X	X	X	X	X
Framing Meaning Making Through the Lens of History		X		X				X			X	
Learning History	X	X	X	X	X	X	X	X	X	X	X	X

	Emma	Ezra	Johanna	Julia	Kevin	Maya	Nathalie	Pablo	Renata	Simone	Wendy	Zora
Decolonizing Trauma and Healing												
Depathologizing Trauma	X	X		X	X	X	X		X	X	X	X
Adopting a Broader Perspective on Trauma	X	X	X	X	X	X	X	X	X	X	X	X
Enabling Relational Healing	X			X		X	X		X	X	X	
Embracing Culture-Centered Healing Interventions	X	X	X	X	X	X	X	X	X	X	X	X
Mobilizing and Building Capacity												
Visualizing Options and Possibilities	X	X	X	X	X	X	X	X	X	X	X	X
Celebrating Indigenous Roots	X		X	X	X	X	X		X	X	X	X
Developing Skills			X			X			X	X		X
Rallying Allies	X	X	X	X	X	X	X	X	X	X	X	X
Translating New Awareness, Knowledge, and Skills into Action												
Acting at the Personal Level	X		X	X	X	X	X		X	X	X	X
Acting at the Collective Level	X	X		X	X	X	X	X	X		X	X

Core Category: Promoting Mindful Engagement

Each of the six empowering processes delineated by the participants seemed to promote mindful engagement by enabling people to better connect and engage with their own and their community's stories, their history, the problematic in their lives, and their social world. The participants promoted mindful engagement by facilitating meaning making in context and purposeful action. Promoting mindful engagement through meaning making in context is captured in the following excerpt from Wendy's second interview.

> At the community level, the work was around helping people understand for themselves why they were feeling the way they were feeling and giving them some context. You know, it's not that you, there's something terribly wrong with you personally.

The people were helped to understand their challenges and life situation in relation to the lived experiences and stories of fellow community members. They were able to contextualize their personal struggles and experiences of hardship within broader social problematic patterns and the history of their communities and their ancestors. Through their involvement in the interventions, the people were able to view their physical and behavioral responses to trauma through a wider angle lens and to conceptualize trauma as a shared human experience. Additionally, the participants helped community members to connect with their resilience and their Indigenous heritage and wisdom. The increased awareness and knowledge of themselves and the world around them allowed the people to become more involved in their lives and in their communities and societies. They experienced greater agency and self-determination as they began to identify alternative options and possibilities, develop new skills, and rally the support of allies. The participants helped community members translate their new awareness, knowledge,

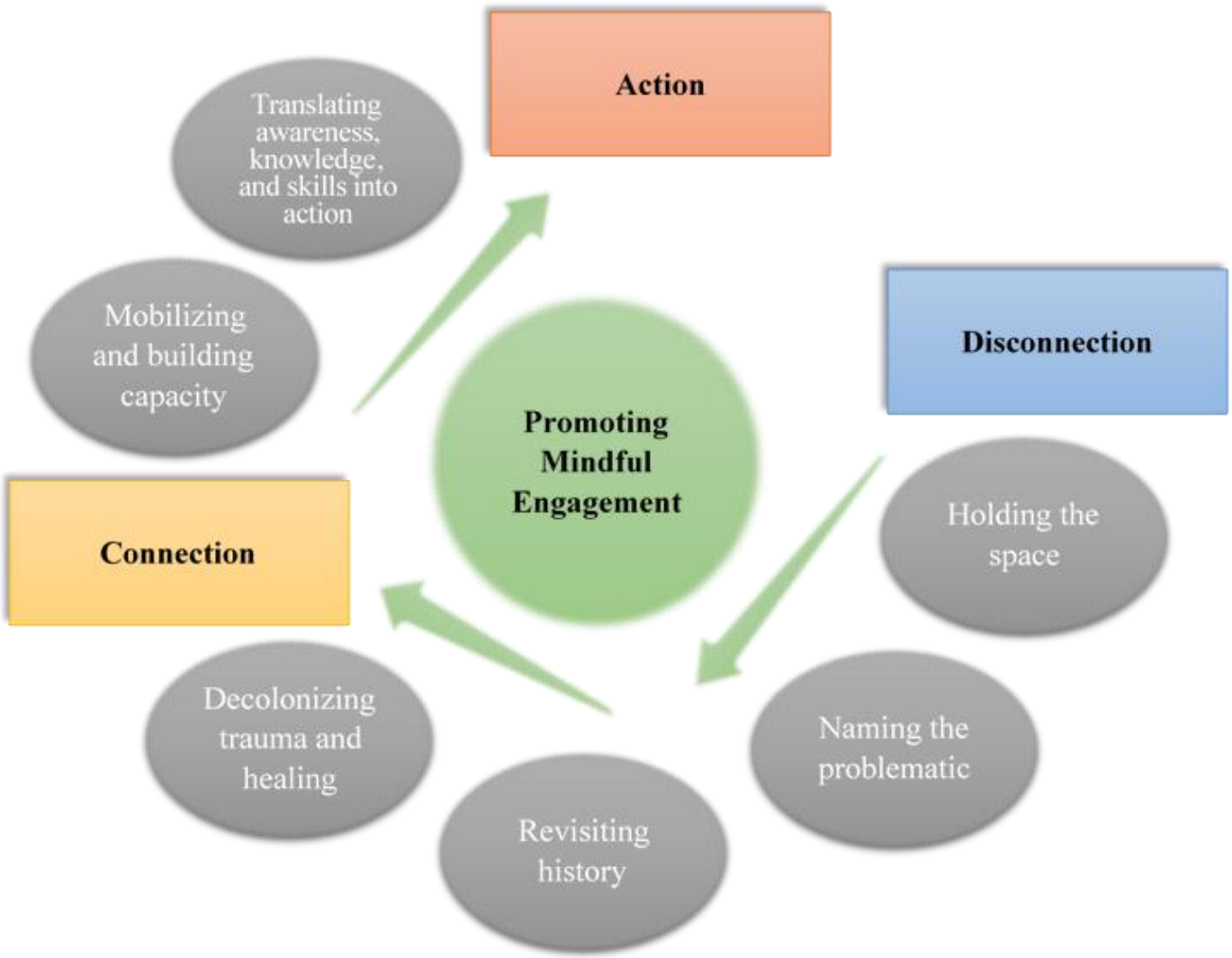
and skills to active engagement at the personal and collective levels. This stage-like process is cogently illustrated by Emma.

> It's like, how do I create the capacity for social groups to analyze their own situation, to name and know what's happened historically, so that the historic trauma then fits into the human rights they have under the UN declarations. See, they don't have them. And so what they're saying to their government, "We want this. We want the police to be doing this. We want the Health Department to be doing this. We want our children to be taught our history, not somebody else's history, but our history in this country. We want the Department of Environment to stop the timber getters coming in or the mining companies coming in from overseas and damaging our country." So, can you see that out of historic trauma, when people start to understand their own stories, they become empowered and active? They want change.

The results seem to indicate that as the people became more engaged and connected with their life challenges and the world around them through expanded awareness and knowledge, they became more involved in their lives and in their social environment through meaningful action. By promoting mindful engagement, the participants seemed to have helped the people transition from a state of disconnect to connection and finally to action. Figure 4 illustrates the final theoretical model.

Figure 4

Final Theoretical Model



Note: The sequencing of the empowering processes between one stage and another may be different.

Disconnection

This phase is characterized by alienation and a lack of awareness and knowledge of self, the problematic, history, and the social world. People and communities have trouble to make meaning of their situation and their social conditions within context.

> In fact, I had a conversation with somebody this morning who's working in a very remote part of Australia, a place where I've lived. And she just got there, and she's going to be working with youth and on family violence issues. And she said to me, "The trauma here in this town is everywhere. It's just that people can't see it, they're just living it." (Emma)
>
> That is why the idea of historical trauma or how we experienced it, and how we, how we've been affected, or the community has been affected, the people that I work with. It's ongoing, in a sense, because of that connection. Of course, they may not make that connection. (Zora)

The disconnection is usually manifested through denial, passivity, and resistance that enable people and communities to put up with the dire conditions, but meanwhile they remain trapped in historical trauma patterns of shame, powerlessness, hopelessness, anger, and distrust. People are typically reacting rather than responding to the challenges in their lives during this phase. The following interview excerpts illustrate the behavioral patterns that characteristic of the disconnection phase.

> So again, this is this historical thing that had crept into the family. And the women had felt shamed and powerless. So, their shame and their powerlessness was exhibited in them laughing and joking. (Emma)

And so we're not meaning making and developing fresh responses based on a clean slate. You're developing new responses inside of already shaped trauma responses, inside of already shaped trauma responses, and so the spiraling gets more intense. (Ezra)

There's a tremendous amount of anger and pain, and self-destruction, and passive suicidality. (Johanna)

There can't be any space for truth, and just having those at times challenging, but at least authentic discussions. That's not possible because- Then it's just attack, attack, attack, attack. And then anyone who's pointing out, "Okay, how can we solve this problem constructively?" could be viewed as like an outsider attacking, or- [sighs] It's personalized as a message of rebuke or criticism. (Johanna)

That even in families where there is known domestic violence, known sexual assault, like known problems, the community will turn a blind eye if they see a family member from that family passed out drunk outside of their door. They just won't help them. They won't, they won't want to acknowledge what's happening because- Yeah. It's like that adaptive denial, right? They just wanna keep going, not see it, like not talk [sighs]. (Johanna)

We certainly are seeing in our Indigenous communities, is people never wanted to talk about what happened to them. They never told their children. (Kevin)

So, you know, that's one of my pet peeves of where a lot of the rage and anger comes from is disconnection. (Nathalie)

And, you know, it was fine, but there were lots of things that were around it that were quite dangerous. So, and again, a lot of that came out of the idea that there was no real intervention on the issues that they were grappling with. There was no- I mean, kids

were committing suicide. You know, there was, there were sexual assaults. There was, there were addictions. There was alcoholism and violence. There were bootleggers. The bootlegger was the Chief's brother, so nobody could do anything about it. So there was all kinds of reasons why getting to the question of historic trauma and how to resolve it was, you know, was continuously pushed further, further back. (Wendy)

When I asked the minister in the community who was from the community, he was Native, from the community, Anglican, and I asked him about speaking to people about residential schools, he just kind of looked at me. And then in church that Sunday, everything was in Oji-Cree, because they speak Oji-Cree up there. And in church, he said in English, "Anybody who speaks about the residential school experience is like a pig rolling in their own filth." And he said that in English. And I remember at the time thinking that was kind of harsh. And then later I realized that was for me. He wanted, you know, he wanted to tell me, "You don't talk about this. I don't want people here talking about this. So you don't get to ask them." (Wendy)

Dissonance is another quality of this phase. While people may not be able to understand their lives in context, they do recognize that their lives could be different and better. Dissonance can sometimes motivate individuals and communities to reach out for help.

And the community knows that it has to do something for itself, but it feels powerless. So, they kind of talk around and next thing I get a phone call. "Can you come?" (Emma)

It’s like knowing something's wrong without knowing how to fix it, so the circle just continues. (Johanna)

Because in a story, if somebody is telling you a story and it's a problem story, what you ask them is, what you listen for is when they say, "Well, it should have been this way. It

could have been that way. It would have been this way if [emphasis]..." What could, should, would, might be is a discussion of the narrative within which their story is being told. So they're telling the story, but there's a gap between the way that the story is actually being experienced and the narrative that describes how it should go. (Ezra)

Connection

The connection phase is marked by greater awareness and knowledge as people and communities begin to construct new meanings around their life situations. They are able to understand themselves and their struggles in relation to their community, dominant social patterns, and their historical legacy. They are able to understand that their behavior and the culture around them are all a response to historical violence and trauma that continue to prevail in the present. As people begin to make these connections, they are able to engage more effectively in their lives and in their social world, and respond to challenges and problems instead of reacting to situations. They become empowered to step away from the shame, silencing, blame, powerlessness, and hopelessness. The role of mental health practitioners during this phase is to facilitate critical consciousness and meaning making in context. The empowering processes of holding the space, naming the problematic, revisiting history, and decolonizing trauma and healing seem to help people transition to the connection phase. The following interview excerpts capture some of the unfolding that takes place during this phase.

So we, we go back and, and we understand the history. We understand the history as the source of the narrative. Because people need to have a sense, to understand the perspective from which they're making meaning of the world today. (Ezra)

And it's, it's helpful sometimes because when people realize, "Oh, that's not like just a hard fact. That's just the meaning that I've made because of, you know, this other..." That

also gives them a sense of agency where they realize, "Oh, I can choose to do something different with that. I could choose to make different meaning out of that." (Ezra)

So that's, that's why I think it's important to look at the historical dimension, to point it out and look at how that links to what we're experiencing right now in our own lives, in our bodies, and our cultures, and our communities, and our countries, and in the international system. (Julia)

It's like as somebody is reconstructing their story, if there's a bigger story that's being constructed, there is an ability to bring your own story into that bigger story. (Julia)

That gave me the space to give people a context to what was around them, and what they were experiencing. (Kevin)

And one of the quotes that I have in the school, which my students are going to be tired of hearing after two years with me is connection is the correction. So we start by making those connections. … We work with the families and we do all kinds of different exercises to get the connection and communication going again. (Nathalie)

And I saw him about two months later... He was so happy, like he was so different. But just to be able to unburden this piece that he was carrying in his life, it was very important part. And that is historic trauma lifted, right? It has been acknowledged and lifted. (Wendy)

Action

The ultimate purpose of any intervention is to mobilize people toward personal and collective action. The action phase is characterized by a sense of agency, self-determination, efficacy, and accountability. People feel empowered to translate their new awareness and knowledge into concrete action. They begin to recognize that they have choices and are not

constrained to live in toxic historical patterns. People are motivated to work on themselves, build on their skills, collaborate with others, and rally the help of allies. Action enables them to transcend their challenges and to grow and flourish. Mental health practitioners can assist individuals and communities to get to the action stage by highlighting existing resources and strengths, facilitating skills development, helping them identify alternative possibilities and options, and encouraging them to translate what they learnt into personal and collective action. The empowering processes of mobilizing and building capacity, and translating awareness, knowledge and skills into action seem to help people transition to the connection phase. The following excerpts illustrate the behavioral patterns that are typical of this phase.

> Two things, they're dealing with the truth. And secondly, they've got active in, in working to prevent anything happening further. So, they've got a strength in them now to stand up and do good work. (Emma)
>
> When people start to understand their own stories, they become empowered and active? They want change. (Emma)
>
> And so you can do that in war-torn countries, in developing countries, in any neighborhood, in most organizations. I've found it's possible to do it in organizations that are in conflict, in churches that are in conflict, in neighborhoods and communities. It's the same practice naming the narrative, naming the dominant and the, and the counter-narrative, and then figuring out together what do we need to make this other narrative, this preferred narrative, our habit. (Ezra)
>
> What I want to do is allow them to notice that their privilege and your lack of privilege are responsive to the same set of conditions." And many of them, when recognizing that they'll be glad to change the system. They'll be glad to adjust, make adjustments, because

it's not like we're trying to take stuff away from them. We're trying to create the access so that everybody has full and fundamentally equitable access to the things that they need, right? (Ezra)

So, you know, it's, it is a continuum that, that people have to try to figure out how to understand and how to make, how to action. How do we action this? (Wendy)

Summary of Results and Chapter Summary

In this chapter, I introduced and provided relevant information on the participants who took part in the study. I also provided a step-by-step explanation of how I arrived at the conceptual categories and the final theoretical model. The findings of the study were presented next. Data analysis revealed six conceptual categories, which represent the empowering processes that transpired across the wide spectrum of interventions and initiatives undertaken by the participants to address historical trauma at the community and society levels. These empowering processes were: (a) holding the space; (b) naming the problematic; (c) revisiting history; (d) decolonizing trauma and healing; (e) mobilizing and building capacity; and (f) translating awareness, knowledge, and skills into action. Each of the empowering processes seemed to promote mindful engagement by facilitating meaning making in context and purposeful action. The people benefitting from the participants' interventions were able to engage better with their own experiences, the problematic in their lives, their history, and their social world. Mindful engagement seemed to enable people to transition from a state of disconnection to connection and eventually to action. I discuss these finding in relation to the research questions and relevant literature in the next chapter.

CHAPTER V

DISCUSSION

Extant literature on collective mental health interventions that address historical trauma is limited, fragmented, largely theoretical, and mostly unrelated to the field of counseling. The purpose of the present study was to examine how mental health practitioners address historical trauma at the community and society levels, and to explore the functions that mental health counselors can assume in collective historical trauma interventions. The study shed light on six empowering processes that transpired in the interventions delivered by the research participants to address historical trauma at the community and society levels. Each of the six empowering processes identified by the participants seemed to promote mindful engagement through increased awareness, knowledge, skills, and purposeful action. Mindful engagement seemed to enable people to transition from a state of disconnection to connection and eventually to action. In this chapter, the research findings are summarized and discussed in relation to the research questions and relevant existing literature. The implications of the results for counselors and counselor educators are presented and recommendations for future research are provided. I conclude the chapter by examining the limitations of the study and my personal reflections.

Philosophical Foundations

The study was situated within a constructivist research paradigm. Constructivism postulates that reality is socially constructed, meaning that people make sense of themselves and the world around them through their interactions with their social surroundings (Lincoln & Guba, 1985). In constructivist research, the findings are co-created by the researcher and the researched who are interlocked in a transactional process, influencing each other (Guba & Lincoln, 2005). My role as the researcher was, therefore, to reconstruct how the participants

construed meaning around their experiences, behaviors, and actions in relation to their work with communities and populations affected by historical trauma. The study results are a byproduct of my social transactions with the participants and represent the co-constructed meanings that transpired from those interactions (Grbich, 2013; Lincoln et al., 2011). The final analytic model represents a co-constructed theoretical product that reflects the plurality of the participants' voices, experiences, perspectives, and social realities.

Discussion of Results

In this section, I discuss the study results in relation to the research questions and extant literature on the topic. The study addressed the following research questions:

- How do mental health practitioners address historical trauma at the community and society levels?
- What functions can mental health counselors assume in the delivery of collective historical trauma interventions?

Research Question 1: How do mental health practitioners address historical trauma at the community and society levels?

The data analysis revealed six conceptual categories, each representing an empowering process that was identified by the participants. These empowering processes were: (a) holding the space; (b) naming the problematic; (c) revisiting history; (d) decolonizing trauma and healing; (e) mobilizing and building capacity; and (f) translating awareness, knowledge, and skills into action. These empowering processes constituted the building blocks of the interventions delivered by the mental health practitioners who participated in the study. The participants called into play these empowering processes to address the phenomenon of historical trauma and its impacts on individuals, families, communities, and societies.

These empowering processes featured differently across the wide variety of interventions and initiatives undertaken by the participants to address historical trauma at the community and society levels. In other words, the identified processes shed light on the important elements present across the spectrum of interventions; however, participants implemented different strategies and approaches to elicit these empowering processes. For instance, establishing safety was a key aspect of holding the space that was emphasized by all participants. However, Johanna and Simone, the two mental health counselors who participated in the study, paid more attention to confidentiality, whereas Pablo was more concerned about the physical safety of the representatives of the rival groups that were participating in the talks. Other participants focused more on cultural safety. Another example is how participants embraced culture-centered interventions in connection with the empowering process of decolonizing trauma and healing. Emma developed a method which she called an "indigenist healing approach" that stemmed from her work with a group of Aboriginal people and revolved around art, music, theater, and dance, whereas some participants tried to adapt Western therapeutic approaches such as CBT, DBT, and REBT to make them relevant to the understandings and worldviews of the cultural groups they were serving. Alternatively, a number of participants took part in healing ceremonies and rituals.

Additionally, the empowering processes were present in varying degrees across the different interventions, which means that there was not an even focus on all of the empowering processes during the interventions. Some interventions placed more emphasis on certain empowering processes and less emphasis on others. For example, Zora's joint project with a local museum in Cape Town centered more on revisiting history to expose slave narratives and their connection to present-day manifestations of harm and injustice than on mobilizing and

building capacity. Conversely, Simone's interventions in Indigenous communities in Canada focused more on mobilizing and building capacity of community members than revisiting history.

At the heart of these six empowering processes was the core process of promoting mindful engagement. The mental health professionals who participated in the study seemed to draw upon these empowering processes to promote mindful engagement, which led to increased awareness, knowledge, skills, and purposeful action. Mindful engagement seemed to enable people to transition from a state of disconnection to connection and eventually to action.

Research Findings Related to Literature

Some scholars have made reference to some of the empowering processes identified in the present study, but no empirical study to date has highlighted these processes together. The framework that comes closest to the study results is the transforming historical harms (THH) model (Hooker & Czajkowski, 2013). The THH is a non-empirical model proposed by the Center for Justice and Peacebuilding at the Eastern Mennonite University. It offers a multi-dimensional ecological approach to addressing the present-day harms of historical trauma. The framework is based on four pillars: (a) facing history, (b) making connection, (c) healing wounds, and (d) taking action. The model promotes the application of narrative approaches to raise awareness about history, facilitate the rebuilding of relationships across historical divisions, support trauma healing, and encourage collective action to redress the legacy of historical trauma. The four dimensions specified by the THH overlap with some of the empowering processes identified in the study, namely revisiting history, decolonizing trauma and history, and translating awareness, knowledge, and skills into action.

The pillar labelled facing history shares similarities with the process of revisiting history. Both processes are intended to help individuals, communities, and groups to identify the historical roots of present-day challenges and harms, and make sense of one's own story and the community's story through the prism of history. Hooker and Czajkowski (2013) argued that history must be told from the perspectives of all those who were involved. Similarly, for the study participants, revisiting history meant addressing the history from the perspective of the community or group targeted by the intervention. Some participants also mentioned exposing historical narratives that had been marginalized and obscured by the dominant historical narrative.

The making connection pillar overlaps with the construct of relational healing which was subsumed under the empowering process of decolonizing trauma and healing. In the present study, relational healing symbolized the relational component of collective healing processes, whereby healing happens in relationship with others as people rediscover their connection with one another and start repairing the social networks that were ruptured by the trauma. By comparison, the THH (Hooker & Czajkowski, 2013) focuses more on building authentic relationships with "the other," which means building connections between people on either side of the historical divide. Some of the interventions delivered by the participants drew together representatives from both sides of the survivor-perpetrator construct. For instance, Pablo brought representatives of conflictual groups to the table for discussions and Maya developed a program for perpetrators and survivors of domestic violence to work on their healing side by side. Julia's post-war community interventions in West Africa included both the survivors and the perpetrators of the violence to heal the historical trauma brought forth by the civil war. Some

participants acknowledged that aggressors were survivors of trauma themselves and argued in favor of eliminating the "good-bad binary."

The pillar titled healing wounds intersects with the concept of embracing culture-centered interventions, which falls under the conceptual category of decolonizing trauma and healing. Both processes aim to promote healing at the individual and collective levels. Healing wounds in the THH model (Hooker & Czajkowski, 2013) favors the use of narrative approaches to healing, whereas the concept of culture-centered interventions in the present study embraces a variety of culturally-appropriate healing and therapeutic practices, including adapted Western-based approaches, ceremony and rituals, and narrative approaches.

The taking action pillar overlaps with the empowering process of translating new awareness, knowledge, and skills into action in the present study. Taking action in the THH model (Hooker & Czajkowski, 2013) focuses more on systemic action and social justice advocacy. In the present study, action incorporates both personal and collective action.

The literature on historical trauma contains some reference to specific processes and elements identified in the present study, albeit in a limited manner given the dearth of empirical studies on community- and society-level interventions for historical trauma. Several participants emphasized the importance of helping people gain a wider perspective on the problematic in their stories, and to identify larger social patterns that are contributing to the problems that they are witnessing in their lives and in their communities. The participants explained that the increased awareness or critical consciousness enables people to realize how their predicaments are not a result of personal failings or shortcomings, but instead reverberate broader problematic patterns. The notion of helping people make meaning in context is consistent with the concept of historical trauma. Unlike the diagnostic classification of PTSD, the concept of historical trauma

takes into consideration the dynamic nexus of temporal, proximate, and distal factors that shape the experience of trauma (Sotero, 2006). It accommodates the social and cultural processes and the institutional contexts that prevail upon the trauma experience, as well as the historical legacy of a population.

Furthermore, helping communities to conceptualize their struggles through a systemic lens enables them to construct collective narratives that emphasize resilience instead of inadequacies and deficits. Abramowitz (2005), in a study conducted in the Guinean Languette region, found that members in local communities that constructed public narratives of violence, destruction, and cultural decimation following the civil conflicts in neighboring Sierra Leone and Liberia reported greater post-conflict distress. In communities where the collective narratives conveyed resistance to violence, and community and cultural perseverance, the rates of psychological distress and PTSD symptomatology were lower.

Many of the study participants stressed the importance of helping people and communities revisit their history to uncover the background story framing their present-day challenges. This empowering process enabled people to make sense of their life stories through a historical lens, and to take notice of the connection between what they were experiencing and witnessing in the present, and the history of their community and their ancestors. The AHF in Canada was set up in the late 1990s to promote and support the healing of individuals, families, and communities affected by the residential school system and its intergenerational impacts (Roy, Noormohammed, Henderson, & Thurston, 2015). The AHF (2006) identified three intervention pillars for sustaining a holistic healing strategy, including reclaiming history, cultural interventions, and therapeutic healing. The revisiting history empowering process in the present study shares similarities with the first pillar of the AHF framework, reclaiming history,

which is also known as legacy education. Legacy education represents interventions that help raise awareness of historical traumatic experiences (e.g., residential school experiences) and their impact on individuals, families and communities. By facilitating the understanding of history, this intervention component is a first step in the trauma recovery process (AHF, 2006).

The second intervention pillar proposed by the AHF (2006) is cultural interventions, which represent interventions that enable people to reconnect with their cultural heritage and traditions through storytelling and sharing of traditional knowledge, traditional ceremonies, language programs, and other activities. These experiences are intended to reinforce self-esteem, cultural identity, and a sense of belonging, aspects necessary to the healing process. This second pillar overlaps with the practice of honoring Indigenous roots found in the present study. Most of the participants highlighted the importance of honoring Indigenous roots and resources as a way to mobilize and build the capacity of communities affected by historical trauma. They encouraged people to connect to their cultural heritage and to participate in traditional ceremonies and activities. In some cases, the participants themselves took part in cultural ceremonies and rituals. They also directed people to seek support from Indigenous services that already existed in their community setting. The participants claimed that uplifting Indigenous roots and resources instilled a sense of cultural pride and emphasized existing cultural protective factors that support healing and growth.

It can be argued that honoring Indigenous roots and resources helps promote cultural continuity. Chandler and Lalonde (1998), in a study with First Nations communities in Canada, found that communities that had higher cultural continuity had lower rates of youth suicide. The authors concluded that that cultural continuity serves as protective factor against behavioral health problems. Their findings suggested that supporting cultural continuity and helping

communities reconnect to their cultural heritage are promising avenues to promote resilience in groups affected by historical trauma.

All the study participants emphasized the need to deliver interventions that were culturally appropriate and meaningful to the people and communities with whom they were working. Several participants drew upon the Indigenous practices and wisdom, and integrated that knowledge in their interventions. Some incorporated ceremony and rituals in their work. A number of participants adapted Western therapeutic approaches to make them relevant to the understandings and worldviews of Indigenous peoples, whereas others applied narrative approaches and blended in cultural-expressive arts such as drama, dance, and painting, and alternative therapies such as somatic-based approaches. The notion of culture-centered interventions resonates closely with the third intervention pillar of the AHF (2006), therapeutic healing. This pillar represents the delivery of culturally-responsive holistic interventions that include a range of traditional therapies combined with Western-based therapies or alternative therapies. Traditional therapies are grounded in Aboriginal worldviews; they incorporate culturally-based healing strategies and keep individuals integrated within a collective.

Roy et al. (2015), in a scoping review of the literature on interventions that address historical trauma in Indigenous youth in Canada, the United States, Australia, and New Zealand, found that most of the interventions used a combination of traditional healing methods and Western therapeutic approaches. In one intervention that addressed trauma and PTSD, the interventionists modified the Cognitive Behavioral Intervention for Trauma in Schools model by reframing the content of the sessions to address traditional history, historical injustice, and coping through community support (Goodkind et al., 2010). This intervention addressed PTSD

from an American Indian perspective. In another intervention, Veroff (2002) used art projects to encourage youth to explore their identity.

The blending of Western therapies with Indigenous healing methods is consistent with the two-eyed seeing philosophy, which recognizes the value of both Western and Indigenous ways of knowing in research and program development (Marsh et al., 2015). Other researchers have investigated the integration of Western and traditional healing practices (Duran & Duran, 2000; Marsh et al., 2016; Thomas & Bellefeuille, 2006). Some of the reported beneficial outcomes of these blended interventions are increased self-esteem, improved sense of identity, cultural pride, feelings of belonging, and resolution of past trauma (AHF, 2003; Duran & Duran, 2000). Marsh and colleagues (2016) conducted a study that integrated Indigenous traditional healing practices and the Western treatment model of Seeking Safety. The authors reported that participation in the intervention resulted in a reduction of historical trauma symptoms and substance use. It is important to note that most of the empirical research on Indigenous interventions for historical trauma targets individual-level factors, such as self-esteem and coping skills (Roy et al., 2015).

Many study participants complained that culture-centered approaches to healing are generally not recognized as relevant and effective because they do not fit into the dominant medical model. They explained that accessing funding for delivering or researching these types of interventions was extremely difficult because these approaches are oftentimes perceived as inferior to evidence-based treatments like CBT. The tension over funding for culture-centered interventions was reported by Bray (2010). The author argued that whereas the demands for culture-centered approaches to treatment and healing have intensified over the years, health care reforms and limited funding tend to tip the scales in favor of time-limited, cost-effective, and

evidence-based treatment options. Such a bias for empirically supported treatments not only overlooks the unique needs of ethnically diverse clients, but it undermines the possibility of implementing innovative interventions that promote indigenous healing modalities (Perry, 2013). It also forces a Western worldview upon cultural groups that subscribe to different values and beliefs. This hegemonic imposition of the Western lens on mental health continues to alienate, marginalize, and re-traumatize historically oppressed populations, as pointed out by a number of participants. In so doing, it implicitly reenacts the cycle of violence and subjugation through the same services that are intended to offer relief to traumatized individuals and communities. Several Indigenous researchers in North America have appealed for the removal of subjugative practices and the integration of Indigenous wisdom with Western knowledge and interventions (Brave Heart 2003; Gone, 2007, 2009; Gone & Alcántara, 2007).

Perry (2013) argued that the over-reliance on empirical evidence based on randomized-controlled trials and quantitative designs to validate the efficacy of trauma-focused interventions is another offshoot of the ironclad loyalty to Western values. Such an approach, although beneficial to develop reliable evidence-based treatment formulations for individuals coping with trauma, discounts unorthodox, culture-centered approaches to therapy and research that do not align precisely with the normative, empirical standards imposed by the medicalized Western paradigm. The strict adherence to empiricism limits the range of effective culturally-responsive interventions that can address historical trauma. Quinn (2007) argued for allocating more funding to encourage and support the development of intervention programs that incorporate Indigenous healing practices.

One of the study participants drew attention to the challenge of identifying suitable evaluation instruments to assess the effectiveness of culture-centered interventions, which further

limits the possibility for funding. Roy et al. (2015) noted that only a few historical trauma interventions included in their review incorporated a formal evaluation to assess the effectiveness of the programs. The authors emphasized the need to develop measures to assess the effectiveness of historical trauma interventions. A major challenge in evaluation is balancing Western techniques and Aboriginal worldviews in order to identify suitable indicators of success that are appropriate for Indigenous communities. The authors suggested using mixed- or multiple methods approach to evaluation that caters for Aboriginal worldviews and honors community perspectives and priorities. Roy and colleagues (2015) claimed that finding a solution to assessing treatment outcomes will also address some of the problems with funding agencies that often expect the use of instruments to assess for group-level outcomes. Another problem is developing measures to assess specifically for historical trauma on top of assessing for health and well-being issues related to historical trauma, such as substance use.

Another aspect emphasized by the participants is depathologizing trauma. Several participants expressed skepticism toward the dominant Western treatment paradigm with its tendency to pathologize distress. Similarly, several historical trauma scholars criticized the narrow focus of current trauma interventions which reflect the Eurocentric model of health and illness that revolves around pathology and individual factors (Brave Heart, 2003; Brave Heart & DeBruyn, 1998; Duran, 2006). The limited scope of current trauma interventions makes them unsuitable to address the complex nature of historical trauma and its multilevel impacts on affected populations.

Several participants spoke to the need to uplift the strengths and resilience of the people and communities as a strategy to depathologize trauma. Most of the participants viewed trauma-related behaviors as survival responses that indicate the people's resilience in the midst of

adversity. They argued that mental health professionals must shift the conversation on trauma by focusing more on the people's resilience. The observations made by these participants echo what other scholars have noted. Evans-Campbell (2008) claimed that current models of psychological trauma tend to highlight the negative outcomes of traumatic incidents. In fact, it is only recently that trauma scholars have begun to shift their attention to the study of how people recover and restore their well-being in the wake of traumatic experiences. Because the concept of historical trauma is grounded in psychological trauma literature, most of the scholarship in this area has revolved around adverse behavioral health impacts (Gone, 2013). Some authors have argued that historical trauma could be simultaneously a potential source of distress and vulnerability and an opportunity to cultivate resilient traits and behaviors (Mohatt et al., 2014; Novac & Hubert-Schneider, 1998). Cross (1998) claimed that many African Americans who were freed from bondage and their offspring constructed lives that celebrated close family and community connections. Similarly, Evans-Campbell (2008) explained that historical legacy of subjugation prompted many indigenous communities to preserve community ties and their cultural heritage.

Several historical trauma scholars have made a case for interventions that target the systemic factors that allow historical trauma to persist (Brave Heart, 2011; Roy et al., 2015). Along the same lines, Silove and Steele (2006) highlighted the importance of repairing institutions and systems to create communal coherence. In the present study, a number of participants reported how some people applied their new awareness and knowledge to engage in action at the collective level, and became change agents in their communities and societies. Additionally, quite a few interventions delivered by the participants targeted systemic changes. Ezra worked with key community players and helped them to identify alternative narratives to

the dominant oppressive narrative. He encouraged them to implement changes in systems and structures in alignment with their preferred narrative such that everyone could experience full flourishing. Pablo delivered society- and international-level interventions to achieve a peaceful resolution of ongoing conflicts that perpetuate historical trauma. Julia and other team members incorporated elements of community development as part of their historical trauma interventions.

Research Question 2: What functions can mental health counselors assume in the delivery of collective historical trauma interventions?

All six empowering processes identified by the study participants are consistent with the scope of practice and the knowledge and skills of mental health counselors. Holding the space, naming the problematic, mobilizing and building capacity, and personal action are regarded as integral functions of counselors' professional practice and are widely covered in counselor preparation programs. Although some aspects of the remaining empowering processes, including revisiting history, decolonizing trauma and healing, and collective action may not be defined as traditional counseling practices, they still fall within the remit of duties assumed by mental health counselors.

Research Findings Related to Literature

Holding the space constitutes the first step in any counseling interaction, which is building an effective therapeutic relationship that is grounded in safety and trust (Young, 2013). The therapeutic relationship is regarded as the heart of therapy and there is strong empirical evidence suggesting that the therapeutic relationship is a key ingredient in therapy success (Ardito & Rabellino, 2011).

Naming the problematic is another core process in counseling that builds upon the therapeutic relationship. Counselors are constantly inviting clients to discuss and explore the

problematic in their lives and make meaning of their stories. In line with the accreditation standards by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016), counselor training programs are expected to equip graduate counseling students with an array of basic counseling skills, such as active listening, invitational skills, and reflecting skills, that can be used to encourage clients to share aspects of their life stories and discuss difficult issues. Counselors are also trained to conceptualize clients from a systems perspective, which is another CACREP (2016) standard addressing the professional identity of counselors.

Mobilizing and building capacity and facilitating personal action are also fundamental aspects of the professional identity and work of counselors. The goal of any counseling intervention is to facilitate change in clients' lives, and to empower clients to assume responsibility for their lives and be able to problem-solve on their own (Remley & Herlihy, 2016). Counselors believe that clients are capable of developing the necessary skills that will help them grow and enjoy wellness. These latter empowering processes were distinctly evinced by the two mental health counselors who participated in the study.

Revisiting history, decolonizing trauma and healing, and collective action are consistent with the counselor's developmental domains articulated by the *Multicultural and Social Justice Counseling Competencies* (Ratts et al., 2015) and the *American Counseling Association Advocacy Competencies* (Toporek & Daniels, 2018). Multicultural and social justice competent counselors are expected to gain knowledge of the historical events and current issues that shape the worldview and experiences of clients from marginalized backgrounds, and to facilitate clients' critical consciousness by helping them understand their life situation in context. Counselors are also expected to employ interventions that align with the cultural backgrounds

and worldviews of clients. Lastly, the *American Counseling Association Advocacy Competencies* stipulate that counselors are responsible to facilitate self-advocacy in clients by helping them to develop skills and resources to advocate for change in their social environments. Mental health counselors are also tasked to engage in systems and social/political advocacy to confront systemic and policy barriers that undermine the mental health and well-being of clients.

The counseling profession is grounded in the wellness model of mental health. Unlike other mental health professions such as psychiatry, clinical psychology, and clinical social work that tend to operate from the medical model with its focus on pathology and illness, counselors have embraced the wellness model of mental health as their primary orientation to helping people (Remley & Herlihy, 2016). The goal of counseling is to support people to achieve positive mental health and wellness to the extent possible. In line with the wellness model, counselors adopt a broad perspective on wellness by taking into account different facets of well-being, such as physical health, career, financial status, spirituality, leisure activities, and sexuality (Remley & Herlihy, 2016). Counselors' commitment to the wellness model of mental health is consistent with the processes of depathologizing trauma and promoting a broader understanding of trauma that were identified in the study.

In this section, I discussed the results of the study in relation to the research questions and extant literature. Next, I examine the implications of the findings, recommendations for future research, and the limitations of the study.

Implications

In this section, I discuss the implications of the study results. I start by addressing the implications for counselors and the counseling profession. Next, I consider the implications for counselor educators.

Counselors and the Counseling Profession

All of the empowering processes identified in the study fall within the scope of practice and skill set of mental health counselors. However, the dearth of counseling literature on historical trauma and historical trauma interventions, as well as the challenges encountered in the present study to identify and recruit counselors, suggest that this area of practice and study may not currently be as central to the work and efforts undertaken by professional counselors. Counselors and the counseling profession in general are encouraged to pay closer attention to historical trauma and to the way that counselors can address this phenomenon and its impacts at the individual and collective levels. Drawing upon a compelling statement made by one of the participants, mental health counselors who uphold social justice cannot overlook the histories of the people and the communities they serve, especially when the history is the source of present-day injustices that continue to undermine the mental health and well-being of individuals, families, and communities. Addressing historical trauma at the individual and collective levels enables counselors to take a proactive stance by interrupting the interlocking cycles of unhealed trauma and violence and preventing them from getting dragged into the future.

All the study participants made a case for the need to deliver collective healing interventions to address the historical harms of widespread political violence and oppression. Many argued that individual interventions are not sufficient to address historical trauma. It is therefore recommended that the counseling profession starts emphasizing the role of counselors in community-based interventions while continuing to acknowledge the need for one-on-one interventions.

Community-based interventions require greater collaboration with community leaders and members as well as other service providers and mental health professionals. It is important

that counselors identify opportunities to increasingly work as part of interdisciplinary teams, especially when addressing complex phenomena like historical trauma that cannot be singularly addressed by one profession.

The counseling profession may also need to review its codes of ethics and practice to ensure that the principles enshrined in these documents are supportive of community-based interventions in different cultural contexts. It is important to explore how ethical principles such as confidentiality and professional boundaries, which tend to translate better in individualistic cultures, can be adapted to effectively accommodate historical trauma interventions in collectivistic cultures. When reviewing current ethical principles, it is important to keep in mind that historically disenfranchised populations tend to lean more toward collectivistic values.

It is further recommended that mental health counselors revisit their understanding of trauma and healing to ensure that they do not perpetuate oppressive beliefs that continue to pathologize and stigmatize trauma. They are encouraged to identify ways to normalize trauma as a shared human experience and to frame trauma-related behaviors as a survival response to extreme hardship and overwhelming conditions. Additionally, counselors must ensure that trauma interventions address all aspects of individual functioning, including the physical, emotional, cognitive, social, and spiritual dimensions. Counselors who would like to work in this field are encouraged to be open to learning about Indigenous healing practices and their value to promote healing and well-being, and avoid dismissing these culture-based approaches in favor of more scientific and evidence-based therapies. Taking steps in this direction will enhance the cultural competency of mental health counselors. Quinn (2007) suggested offering more training to mental health providers in culturally-appropriate practices and interventions.

Finally, mental health counselors are encouraged use their advocacy and leadership skills to advocate for the rights of historically marginalized communities and groups at the institutional and systems level. The perpetuation of structural violence and oppression through the unequal distribution of wealth and access to services and resources, and institutional racism and discrimination, echo historical traumagenic experiences that continue to undermine people's mental health and well-being in the present. Advocacy efforts at this level can be targeted to rally the support of allies who are willing to do their part to mitigate the deleterious effects of historical trauma on entire communities and populations. Counselors need to engage in professional advocacy by educating other mental health professionals and policymakers on how counselors can contribute to addressing the enduring legacy of historical trauma.

Recommendations for Future Research

The conceptual categories and the final theoretical model shed light on an array of processes and elements that are integral to how mental health practitioners address the phenomenon of historical trauma at the community and society levels. The empowering processes and the conceptual model were identified by the participants. As a follow-up to the present study, it would be interesting to investigate the experiences of the people who took part in the interventions to understand how they make sense of their involvement in these types of interventions and their impact on their lives. Future research can explore those factors and processes that community members and groups find meaningful and beneficial.

The theoretical model presented in the study was based on a small sample of participants who were working in specific cultural contexts. Future research needs to assess the generalizability of the model and its components across various interventions designed to redress the legacy effects of historical trauma in different populations at the collective level.

Research on community- and society-level interventions for historical trauma is limited; thus, more empirical research is needed that assesses the effectiveness of such interventions. Another recommendation for future research is to develop an intervention that incorporates all or some of the empowering processes identified by the research participants and conduct a community-based intervention study to evaluate the outcomes of the program. A pre- and post-longitudinal design study could be useful to assess the effectiveness of the intervention at multiple points in time, such as conducting evaluations at six-month intervals over a two-year period.

As discussed in Chapter II, there is a paucity of counseling literature on historical trauma interventions. Also, it appears that not many mental health counselors are working in this field, given the difficulty encountered in the present study to identify and recruit counselors. It would be interesting to uncover the perceptions held by counselors and leaders in the counseling profession with regard to the relevance and significance of delivering collective interventions for historical trauma and the contribution that counselors could offer in this domain. A mixed-methods study could be used to investigate this topic.

A final recommendation is to explore how counselor preparation programs are addressing the subject of historical trauma in the curriculum. A survey study could be conducted to understand where and how historical trauma is covered in counseling graduate courses. It would be interesting to understand how some of the factors uncovered by the present study, such as the histories of people and decolonizing trauma and healing, are being addressed if at all.

Counselor Education

The findings of the present study suggest that counselor training programs might strengthen the preparation of their graduates by covering the histories of different populations

and the concept of historical trauma in the curriculum. It is important that trainee counselors have a clear understanding of how the histories of people shaped their current conditions and challenges. Without such an understanding, training in diversity and social justice issues would be a hollow endeavor because acknowledging the background story sharpens our awareness and knowledge of how contemporary problems have manifested in the first place. Knowing the histories of people can counter harmful tendencies to stereotype and pathologize historically marginalized groups in society. Quinn (2007) recommended socializing mental health practitioners-in-training to the ongoing effects of colonization. Roy et al. (2015) underscored the importance of educating mainstream mental health professionals about historical trauma and issues in Aboriginal health and well-being.

Another recommendation pertaining to the training of future counselors is promoting a systemic understanding of the problems faced by clients and communities. Trying to support people without situating their lives and their challenges within the broader social, cultural, political, and historical contexts can lead to blaming clients and communities for their problems. Shifting the responsibility onto the people who are affected by historical trauma will further disenfranchise them and silence their voice. Redressing the legacy of historical trauma can happen only when its current manifestations are understood in relation to each other and as part of a collective whole. In other words, one cannot address individual challenges without a clear understanding of how those challenges relate to systemic and historical factors.

Lastly, it is important that counselor education programs encourage a decolonized understanding of trauma and healing that is grounded in the principles of well-being, diversity, and freedom. It is not sufficient to train future counselors in trauma-informed care unless counselor educators address how counselors can decolonize trauma and trauma care, especially

when working with populations affected by historical trauma. Counselors-in-training should also gain a basic understanding of Indigenous healing practices and their value to promote wellness. They should be encouraged to do further reading and attend specialized training events on Indigenous healing practices. Counselor educators are encouraged to help students broaden their perspective on what counseling and counseling relationships might look like in different cultural contexts. The final implication of the study results is related to CACREP. Future revisions to the CACREP standards should reflect a commitment to decolonizing counseling practice so that it becomes a more culturally-responsive tool to uplift and advance the well-being of historically disenfranchised populations.

Limitations

The findings of the study were subject to a number of limitations inherent to the type of data gathered, sample size and composition, and the research design and methods used. First, the use of qualitative data coupled with a small sample size limits the generalizability of the results to different populations and sociocultural contexts. The conceptual categories were based upon the subjective understandings and experiences of the interviewed mental health practitioners, which were situated in specific cultural settings. The applicability of the theoretical model in contexts outside the social and cultural realities of the study participants needs to be inferred with caution.

Additionally, the study results were based on data collected exclusively through intensive interviewing, which limits the credibility of the findings. The credibility of the analytic categories and the final theoretical product could have been enhanced by means of triangulation by drawing upon multiple sources of data, such as reviewing reports and documents related to the interventions and interviewing community leaders and members who participated in the

interventions. It was not possible to triangulate findings in the present study due to time constraints.

Another limitation of the study is linked to the use of online interviews to gather the data. I did not encounter any major technical issues that interfered with the quality of the research interviews, such as problems due to poor Internet connectivity and lack of familiarity with the videoconferencing technologies as suggested in the literature (e.g. Hamilton & Bowers, 2006; O'Connor & Madge, 2001; Salmons, 2015). However, my interactions with the participants were limited to some extent by the fact that I could only get a head shot view captured by the webcam, and therefore it was not possible to observe all the body movements and posture of the participants (Bayles, 2012). It is unclear how this visual barrier influenced, if at all, rapport building with the participants and ultimately the quality of the gathered data.

The composition of the study sample consisted of both licensed mental health professionals who had received traditional mental health training and non-licensed practitioners who, despite having extensive experience delivering behavioral health interventions and having received training in trauma awareness and recovery, did not identify as mainstream mental health professionals. The distinct professional identity of these latter participants may have influenced both how they intervened in communities and with groups affected by historical trauma and how they construed meaning around their experiences. It is unclear if a more homogenous sample of licensed mental health professionals would have generated similar or different results.

Finally, the generalizability of the results was influenced by the sampling procedures and criteria. First, many of the mental health practitioners who were invited to participate in the study had their work and endeavors in the field of historical trauma published in scholarly journals or in the World Wide Web in the English language. Additionally, only mental health

practitioners who were fluent in the English language were recruited. Only mental health practitioners who had access to the Internet and to the necessary hardware and software could participate in the study. These criteria may have excluded mental health practitioners who could have made a valuable contribution to the subject of the study.

Personal Reflections

Conducting the study has been a challenging and intense experience, yet it was a rewarding and growth-affirming journey on all counts. The research interviews with the participants were the highlight of this project. My conversations with this cadre of highly experienced practitioners and scholars were transformative. They not only shared their time and knowledge, but they shared their wisdom, their passion, and their humanity. The significance of my interactions with these outstanding people prompted me to reorient how I make sense of people, social processes, systems, and histories. They opened a window onto the world of Indigenous peoples across the globe that brought me in closer contact with the harrowing legacy of colonialism. More than ever, I know why this work is so important and pressing if mental health professionals are committed to sparing the human family from senseless violence and unnecessary suffering. I was inspired by the participants' relentless passion for their work with communities and populations affected by historical trauma, and I am determined to continue pursuing this area of practice and study after I complete my doctoral studies.

My exchanges with the participants also helped me reflect on my country of origin and the impacts that centuries of colonization have had on my identity, my family, and fellow Maltese. I recognize more clearly how the world that I grew up in was influenced by the specter of colonialism. I wonder now how much my ancestral and cultural background had unwittingly influenced my interest in this topic.

In terms of the inquiry process, although it was not my first experience of conducting a qualitative study, I still experienced a learning curve as I became acquainted with constructivist grounded theory methods. I had much to learn in terms of the application of constructivist grounded theory methods to gather and analyze data as I sought to develop and refine conceptual categories. One of the major challenges was honoring the plurality of the participants' voices and experiences and not reducing the rich data to simplistic constructs and patterns.

My overall experience working on this study has been humbling as I rolled with the many uncertainties of unprecedented times and events and the research process. The entire process was fraught with uncertainty, which in time gave way to moments of amazement and inspiration. The conceptual categories and the final theoretical product that I ended up with were a long way off from whatever I imagined that I would discover through this research.

Conclusion

In this concluding chapter, I analyzed the results of the study in relation to the research questions and relevant extant literature. The implications of the findings for counselors, the counseling profession, and counselor educators were reviewed next. In this chapter, I also discussed recommendations for future research, the limitations of the study, and my personal reflections.

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APPENDIX A

IRB APPROVAL LETTER

University Committee for the Protection of Human Subjects in Research
University of New Orleans

Campus Correspondence

Principal Investigator: Barbara Herlihy
Co-Principal Investigator: Anabel Mifsud
Date: December 3, 2019

Protocol Title: Exploring Community- and Society-Level Interventions for Healing Historical Trauma: A Grounded Theory Study

IRB#: 04Nov19

The IRB has deemed that the research and procedures of the above-named protocol are compliant with the University of New Orleans and federal guidelines and meets the standard for being exempt from further IRB review according to:

CFR 46.104 (d)(2): Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) and at least one of the following criteria is met:

(i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;
(ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or
(iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and the IRB has conducted a limited IRB review and determined that there are adequate provisions to protect the privacy of subjects and maintain the confidentiality of data.

Researchers maintain the responsibility for ethical research practices in exempt research. Any changes to the procedures or protocols that change the eligibility of the study for exemption must be reviewed and approved by the IRB prior to implementation.

I wish you much success with your research project. If you any questions, please do not hesitate to contact me at [redacted]

Sincerely,

Ann O'Hanlon, Chair
UNO Committee for the Protection of Human Subjects in Research

APPENDIX B

RECRUITMENT LETTER

[Date]

Dear [Name of Prospective Participant],

I am Anabel Mifsud, a Ph.D. candidate in counselor education and supervision at the University of New Orleans in the United States. I am conducting a qualitative study on community- and society-level interventions for historical trauma for my dissertation project under the direction of Dr. Barbara Herlihy. The project is entitled *Exploring Community- and Society-Level Interventions for Healing Historical Trauma: A Grounded Theory Study*, and it has been approved by the Institutional Review Board at the University of New Orleans (IRB # 04Nov19). The purpose of the study is to investigate how mental health practitioners address the collective and multilayered impacts of historical trauma in affected populations at the community and society levels, and to explore the roles and functions assumed by professional counselors in the delivery of collective interventions for historical trauma.

I am reaching out to invite you to participate in the study. If you are a recognized mental health practitioner in your country of residence, have direct experience working with populations affected by historical trauma, and have practical experience in delivering collective behavioral health interventions that address historical trauma at the community and/or society levels, you are eligible to participate in the study.

Participation in the study would involve taking part in two one-on-one online interviews that will be conducted via Skype or Zoom. Each interview will require 60–75 minutes of your time. Interviews will be audio-recorded for data analysis purposes.

Participation is voluntary and there are no foreseeable risks associated with your involvement in the research. If you decide to take part in the study, you are free to withdraw your participation at any time without giving a reason. If you choose not to participate or to withdraw from the study, there will be no penalty.

The study results will be reported in the dissertation manuscript. They may also be published in academic journals and/or presented at professional conferences. Participation is

anonymous and your identity will be protected at all times. Your name and any identifying information will not be included in any publications proceeding from the study.

Although your involvement in the study may not yield any direct benefits to you, your participation will contribute toward a better understanding of how mental health practitioners can intervene to support and empower populations affected by historical trauma through collective interventions. You will be also making a valuable contribution to a field that is in need of more empirical research.

If you decide to participate in this research study, please send me an email at [redacted] to confirm your participation. Please include your name and your preferred email account, as well as your availability for the individual interviews during the months of February and March 2020. Additionally, please read carefully and sign the enclosed Informed Consent Letter, and send it to me in your confirmation email.

Thank you for your attention and for considering my invitation.

Sincerely,

Anabel Mifsud, MS
Ph.D. Candidate, Counselor Education and Supervision
School of Education
University of New Orleans
2000 Lakeshore Drive
New Orleans LA 70148

APPENDIX C

INFORMED CONSENT LETTER

[Date]

Dear Participant,

Thank you for consenting to participate in the study. I am Anabel Mifsud, a Ph.D. candidate in counselor education and supervision at the University of New Orleans in the United States. I am conducting a qualitative study on community- and society-level interventions for historical trauma for my dissertation project under the direction of Dr. Barbara Herlihy. The project is entitled *Exploring Community- and Society-Level Interventions for Healing Historical Trauma: A Grounded Theory Study*, and it has been approved by the Institutional Review Board at the University of New Orleans (IRB # 04Nov19). The purpose of the study is two-pronged: (a) to investigate how mental health practitioners address the collective and multilayered impacts of historical trauma in affected populations at the community and society levels, and (b) to explore the roles and functions assumed by professional counselors in the delivery of collective interventions for historical trauma.

Participation in the study involves taking part in two one-on-one online interviews that will be conducted via Skype or Zoom. As part of the interviews, you will be asked to answer a number of questions about your involvement in delivering interventions for historical trauma at the community and/or society levels, as well as your perceptions and viewpoints on the subject. Each interview will require 60–75 minutes of your time. Interviews will be audio-recorded for data analysis purposes. Because the interviews will be conducted online, access to the internet, a personal computer, and Skype or Zoom are necessary.

Participation in the study is voluntary. If you decide to take part in the study, you are free to withdraw your participation at any time without giving a reason. If you choose not to participate or to withdraw from the study, there will be no penalty. There are no foreseeable risks associated with your involvement in the research. However, you can stop the interview at any time if you feel distressed.

Your data will be treated with strict confidentiality. I will be the only person that will have access to your data. All data will be stored securely in a password-protected device and the interview recordings will be encrypted. Interview recordings will be destroyed upon completion

of the project and interview transcripts will be destroyed six months later. Data will be used solely for the purposes of the research project.

The study results will be reported in the dissertation manuscript. They may also be published in academic journals and/or presented at professional conferences. Participation is anonymous and your identity will be protected at all times. Your data and its interpretation will be presented in anonymized format. Your name and any identifying or potentially identifying information will not be included in any publications proceeding from the study.

Although your involvement in the study may not yield any direct benefit to you, your participation will contribute toward a better understanding of how mental health practitioners can intervene to support and empower populations affected by historical trauma through collective interventions. You will be also making a valuable contribution to a field that is in need of more empirical research.

If you have any questions or require any clarifications about the study, please contact me on [redacted] or [redacted] or the principal investigator, Dr. Barbara Herlihy on [redacted]. If you have any questions about your rights as a participant in the research or feel that you have been put at risk, you can contact Dr. Ann O'Hanlon, the chair of the Institution Review Board at the University of New Orleans on [redacted].

Sincerely,

Anabel Mifsud, MS
Ph.D. Candidate, Counselor Education and Supervision
School of Education
University of New Orleans
2000 Lakeshore Drive
New Orleans LA 70148

By signing below, you are confirming that you have read and understood the contents of the Informed Consent Letter, and you are giving consent to participate in the study.

_____	_____	_____
Signature	Printed Name	Date

APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

Dear Participant,

Thank you for accepting to participate in the study. As part of your participation, you are kindly invited to complete this brief demographic questionnaire. For confidentiality purposes, some of your responses to these questions will be only reported in aggregate format. I would like to reiterate that your data will be always presented in anonymized format. Thank you once again for your contribution to the research.

1. **Gender:** Male ☐ Female ☐ Other ☐
2. **Age:** Choose an item.
3. **Nationality:** Click here to enter text.
4. **Race/Ethnicity/Tribe:** Click here to enter text.
5. **Profession:** Choose an item.

   If you chose "*Other*" in Question 5, please specify: Click here to enter text.

6. **Number of years of experience in the profession:** Choose an item.

Anabel Mifsud, MS
Ph.D. Candidate, Counselor Education and Supervision
School of Education
University of New Orleans
2000 Lakeshore Drive
New Orleans LA 70148

APPENDIX E

INTERVIEW GUIDE

Exploring Community- and Society-Level Interventions for Healing Historical Trauma: A Grounded Theory Study

Interview Guide

- What do you understand by the term historical trauma?
- Tell me about the community in which you work.
    - What is the history of this community?
    - How has this community been impacted by trauma?
- Tell me about your work on historical trauma with this community (including individual and systemic/collective work).
    - How long have you been working with this community?
    - How long have you been working with this community through collective interventions?
- Tell me more about your experiences delivering collective interventions that address historical trauma at the community and society levels.
    - What was/were the target population/s of your interventions?
    - Could you describe the intervention/s? What did it/they involve?
    - Could you describe the circumstances and events that led to the delivery of the intervention/s?
    - What was your role in the intervention/s?
    - With whom, if anyone, did you collaborate in the intervention/s? Could you describe these collaborations? How did these collaborations come about? At which stage/s of the intervention/s did these collaborations take place?
    - What were the intended benefits of the intervention/s? What other benefits came out from the intervention/s?

    - What challenges did you encounter when delivering the intervention/s? In hindsight, what would you have done differently?
    - What local and macrolevel factors, if any, influenced the delivery of the intervention/s?

- Based on your experiences, what are your views of community- and society-level interventions that address historical trauma?
    - What is the need, if any, for these interventions?
    - How, if at all, have your views changed as a result of your experiences?
    - In what other ways, if any, can mental health practitioners address historical trauma at the community and society-levels?
- Based on your experiences, what community and society-level factors need to be considered when delivering these types of interventions?
- Based on your experiences, what relationships and collaborations are important to the success of these interventions? (community members, community leaders, traditional healers, other professionals, other stakeholders)
    - How do you go about establishing these relationships and collaborations?
- Based on your experiences, what suggestions would you offer to other mental health professionals who wants to work in this area?

*****

- How would you describe your contribution in collective historical trauma interventions as a professional counselor?
    - How was your role and involvement in the intervention/s different, if at all, from that of other mental health practitioners?
    - How did your professional identity influence, if at all, your role and involvement in the intervention/s?
    - How did your involvement in the intervention/s influence, if at all, your professional identity as a counselor?
- Based on your experiences, what roles and functions can counselors assume in the delivery of community- and society- level interventions for historical trauma?
    - What unique contribution, if any, can counselors offer in these types of interventions?

*****

- Are there any thoughts about the subject that occurred to you during this interview that you might not have thought about before?

- Is there something else you think I should know to understand better how mental health practitioners can address historical trauma at the community- and society- levels / the roles and functions of counselors in the delivery of collective interventions that address historical trauma at the community and society levels?
- Is there anything you would like to ask me?

APPENDIX F

EXAMPLE MEMO

March 3, 2020

Connection vs. Disconnection

Nathalie stated that the goal of her work is the promote connection which is very interesting. She said that "connection is correction." She defined connection as developing meaningful relationships with others, which helps to bridge the existing disconnect. Nathalie said that most of the anger and violence that she witnesses in communities is symptomatic of this sense of disconnect in relationships. Her argument resonates with what Emma and Julia mentioned. They both mentioned connecting with other community member as a key aspect of their interventions. All three seem to suggest that people heal through connecting with other. The act of connecting seems to counteract the disconnection created by the trauma. Julia trauma causes people to isolate themselves and their stories "get frozen" within. She even suggested that people cannot relate to their own story. It sounds like the people are also become disconnected from their own stories and realities. Emma too, suggested this notion of disconnection from one's own story. She used the phrase "help people find their own stories." It is as if the story is lost even to the people who are supposed to be the owners of the story. When a person finds something that has been lost, they are connecting again with that lost object. What if this idea of disconnection is more than just a rupture in relationships and there is a deeper disconnection across other areas of functioning? What if connection too is a broader process and there are multiple levels of connection? I need to explore this dynamic further.

VITA

The author was born in Pietà, Malta. She received a bachelor's degree in psychology from the University of Malta in 2001 and later earned a master's degree in health psychology from University College London and King's College London. Anabel moved to New Orleans in 2015 to pursue her doctoral studies at the University of New Orleans. She graduated with a Doctor of Philosophy in Counselor Education in Fall 2020. While enrolled in the doctoral program, she co-taught/taught a number of graduate counseling courses, supervised master's-level counseling students, and engaged herself in several scholarly and professional activities, including serving on the executive committee of the UNO Chi Sigma Iota Alpha Eta Chapter and co-leading the Peace and Social Justice Round Table of the International Association for Counseling.

Previously, the author has worked in the public and non-profit sectors and academia. Most of her clinical work has been with persons with HIV and people experiencing homelessness and comorbid issues. Her research interests are historical/generational trauma, social justice and advocacy, the internationalization of counseling and counselor education, and behavioral health services for migrants, refugees, and persons with HIV and long-term illness. She has presented at several conferences in the United States and abroad. Anabel was awarded various awards and grants, including the Rotary Foundation Global Grant Scholarship in 2015, the 2017 Innovate Award for Outstanding Research and the 2018 Doctoral Dissertation Year Fellowship from the University of New Orleans, the 2019 Grand Prize for the American Counseling Association Tomorrow's Counselors Awards, and the 2020 Chi Sigma Iota Excellence in Counseling Research Grant.