# *Investigating "Collective Trauma"*

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Margaret E. Smith, Ph.D.
Adjunct Professorial Lecturer
Program on International Peace and Conflict Resolution
American University, Washington, DC
mesmith45@gmail.com

**Abstract**

Does the intractable nature of certain conflicts arise, at least in part, from the fact that the collectivities involved have experienced past collective trauma that has trapped them in repetitive behaviors and rendered them unable to address their situation creatively? This paper makes a start at addressing this large question by exploring accumulated knowledge and ways of thinking about "collective trauma." Our understanding of the collective aspects of trauma and their implications, despite advances in recent years, remains in its infancy. The term "collective trauma" is used these days to capture the impact of societal disruption in the wake of war, genocide, displacement, colonialism, slavery and natural disaster. Current exploration of collective trauma connects with discussions of the individually-defined versus contextually-defined nature of the self; discussions of helplessness and agency in our understanding of trauma and recovery; of the difference between testimony as a public, rhetorical event and testimony as a private, therapeutic experience; and post-conflict politics.

**Introduction**

Accounts of conflicts and natural disasters during the past twenty-five years increasingly link research on trauma by the therapeutic mental health sector, with research on humanitarian intervention, truth commissions, testimony, redress, victimhood, identity and ethnopolitical programs. We now know that subsequent generations are affected by the traumas experienced by their forebears biologically and relationally as well as rhetorically. All of this captures the collective aspect of trauma. In addition to the term "collective trauma," other terms that are used interchangeably include "mass trauma" or "social trauma" (Krieg, 2009, citing Abramowitz) or "traumatized societies" (Hart, 2006).

The concept of collective trauma is now being introduced in a modern mental health classification in the draft of the WHO International Classification of Diseases (ICD) 11th revision guidelines (cited by Somasundaram, 2014, 49):

> Large scale traumatic events and disasters affect families and society. In collectivistic or sociocentric cultures, this impact can be profound. Far-reaching changes in family and community relationships, institutions, practices

and social resources can result in consequences such as loss of communality, tearing of the social fabric, cultural bereavement and collective trauma. For example, in indigenous and other communities that have been persecuted over long periods, there is preliminary evidence for trans-generational effects of historical trauma.

Supra-individual effects can manifest in a variety of forms, including collective distrust; loss of motivation; loss of beliefs, values and norms; learned helplessness; anti-social behavior; substance abuse; gender based violence; child abuse; and suicidality. These effects, as well as real or perceived family and social support, can also impact on individual resilience and outcomes."

**Trauma, PTS and PTSD**

Trauma, based on western understanding, arises when a person is unable to take effective action to protect her or himself against a threat. In such situations, the release of hormones like cortisol and adrenaline that occurs at the time of the threat does not taper off as it otherwise normally would. Inability to address one's peril, often coupled with the absence of a place to retreat to where one can regain a sense of safety, means that normal body calming processes do not get engaged. The person remains in a state of fight, flight or freeze, (aggression, dissociation or numbness, or a combination). The person is unable to integrate new experience into their life, and continues to organize their life as if the trauma continues. Trauma creates a state of reduced ability to function, and in its most extreme form disrupts life totally. It often creates repetition behaviors that can be understood as an indication that a person is continually trying to work through the traumatic experience. (Van der Kolk, 51-73).

Post Traumatic Stress Disorder (PTSD) is the medicalized expression of this phenomenon, introduced in 1980 into the DSM III in order to capture the situation of returning Viet Nam veterans to the U.S. A person with a PTSD diagnosis has symptoms in the areas of intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. In addition they may show persistent and distorted blame of self or others, and persistent negative emotional state, reckless or destructive behavior, or dissociation or depersonalization (DSM 5). PTSD could be understood as the extreme end of the trauma spectrum: a person with a PTSD diagnosis is not able to function in normal life. Post Traumatic Stress (PTS), on the other hand, is a somewhat less extreme expression of the effects of trauma, and a far more widely occurring phenomenon.

**Lone self or member of a collective**

A starting point for many of the articles in the corpus of literature relating to collective trauma is a discussion of our understanding of the person. Should we regard a person as a lone entity whose behaviors and pathologies arise purely because of inner processes, or should we include context in our understanding of the person?

Even though trauma and PTSD are often accused of being western, individual-based concepts (Muldoon & Lowe, 2012), western society has come to be much more aware in the past fifty years of ways in which environment shapes the self. The centrality of groups and group membership in everyday life has been highlighted by Tajfel and Turner (1986). Tajfel (1974) introduced the concept of "illusory vacuums," in other words the pretense that social context is not relevant to our understanding of the person. Social groups, Tajfel argued, *create* social context.

The mental health field in the US began to take cognizance of this message in the 1970s, when the issue of social context became much more an acknowledged part of the equation with regard to addressing poverty and mental illness (Bronfenbrenner 1979). Uri Bronfenbrenner's ideas, particularly his point about how poverty affects children developmentally, were seminal in the creation of the Head Start program.

Our awareness of the connection between context and the self is far greater in our understanding of non-Western cultures. Anthropologists have coined the term *collectivist culture* for non-Western, cultural groupings that are often discussed in terms of their high context forms of communication. Symbols, agreed manners and definitions of politeness, assumptions about social rank and appropriate ways to address the other can seem a mystery to the newcomer and so underline the tight interactions of the culure. But in such cultures emphasis on *communication* does not fully capture the fact that relationships and social givens are an extension of the self. So when they are disrupted, this is experienced as a trauma.

**How is trauma affected by the collective? or, How is the collective affected by trauma?**

Muldoon and Lowe show (2012), based on their research, four ways that social group membership is linked to Post Traumatic Stress:

1) Evidence that demonstrates that memberships of particular social groups are intrinsically related to the likelihood of experiencing a potentially traumatic event, criterion A1 for a diagnosis of PTSD.
2) Evidence that links membership of particular social groups with the appraisal of traumatic events, criterion A2 for a diagnosis of PTSD.
3) Evidence of the mediating role of political, military, and social identities that buffer the impact of traumatic stress.
4) Evidence of a relationship between group-level factors and available social support that can protect against PTS.

Muldoon and Lowe's four points capture well the situation of stigmatized groups, or groups that fall in a low position on the social hierarchy and are therefore likely to experience the range of problems associated with poverty and deprivation. They don't fully capture the disruption of the social order that war or natural disaster can create, or the way that the self becomes compromised by the assault to the collective.

Kai Erikson captures the aspect of destruction of *connection with others* that is involved in collective trauma. Son of Erik Erikson, Kai Erikson is generally considered the first

person to coin the term "collective trauma" in his publications about the Buffalo Creek flood of 1976.

> By individual trauma I mean a blow to the psyche that breaks through one's defenses so suddenly and with such brutal force that one cannot react to it effectively. This is what clinicians normally mean when they use the term, and the Buffalo Creek survivors experienced precisely that. They suffered deep shock as a result of their exposure to death and devastation, and, as so often happens in catastrophes of this magnitude, they withdrew into themselves, feeling numbed, afraid, vulnerable, and very alone.
>
> (Erikson, 1976, pp. 153 – 154. Cited in Saul, p. 3)

He continues:

> By collective trauma, on the other hand, I mean a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality. The collective trauma works its way slowly and even insidiously into the awareness of those who suffer from it, so it does not have the quality of suddenness normally association with "trauma." But it is a form of shock all the same, a gradual realization that the community no longer exists as an effective source of support and that an important part of the self has disappeared… "I" continue to exist, though damaged and maybe even permanently changed. "You" continue to exist, though distant and hard to related to. But "we" no longer exist as a connected pair or as linked cells in a larger communal body.
>
> (Erikson, 1976, p. 154. Cited in Saul, p. 3)

Erikson implies that a person at Buffalo Creek experienced *both* individual trauma and collective trauma. Others are inclined to leave out the parallel individual aspects when they define collective trauma. Collective trauma is generally described as a large social impact, occurring at multiple levels, "with shared injuries to a population's social, cultural and psychical ecologies," where we see an "impact of adversity on relationships, families and communities and societies at large" as well as the loss of social trust (Saul 2014). Long term social transformation of a sociopathic nature follows collective trauma. (Somasundaram, 2014, 46; Bloom, 1998), cited by Somasundaram, 2014) in this regard.

**PTSD in the context of societal trauma**

The diagnosis of PTSD in the Diagnostic and Statistical Manual contains no reference to social disruption. This demonstrates, some argue, the limitation of the Western frame in relation to collectivist cultures, and in situations of war or natural disaster. (Muldoon & Lowe, 2012)

In addition, PTSD is best understood as a pathology relating to one traumatic event, or a series of events within a circumscribed period of time. Whereas the undermining of cultural ties and social norms that was part of the colonial experience or the result of

marginalization of minority groups, is a gradual process extending over centuries, as Erikson pointed out above.

Another criticism of PTSD's application to non-western cultures is that these cultures often have their own means of addressing traumatic events, which means the bodies of people in these situations may be responding in ways that do not accord with western assumptions. Some suggest that other cultures actually view the events of war differently, and therefore feel less traumatized by them, than do people in the west. Recognition in advance of the possibility of torture, the nature of family support, and religious beliefs may mitigate PTSD following war trauma and torture in some war torn societies (Johnson and Thompson, 2008). Or, poverty and the struggle for survival may cause people to live much more in the here and now and focus less on their own emotional state (Nordanger, 2007b).

Demonstrating the cultural difference in approaching trauma, a study of twenty Tigrayan adults, ten men and ten women, who were victims of the Ethio-Eritrean war, highlights that "avoidance" is a normal coping strategy in this part of the world, whereas the same avoidant behaviors would raise these peoples' scores on standard PTSD measures (Nordanger, 2007a). Key coping concepts that emerged from the research – "diverted thinking" and "distraction" – underline that finding ways *not* to think about their past trauma were significant coping strategies for these people. They rationalized these strategies with a range of beliefs such as the notion grieving will make you sick or blind, that grieving will cause serious damage to other members of your household so you must control your sorrow for the sake of your children, and grieving brings more sorrow because you lose God's protection. The research bears out the proposition that the western trauma framework and its presumption of universality has shortcomings, and its application across the board can be understood as a form of cultural imperialism that has the potential to misconstrue the needs of people in war-torn environments.

In collectivist societies, trauma gets experienced through the larger unit (Somasundaram, 2014, 45). In the face of disaster a family will come together to support each other, to make meaning of the situation, and to find ways to respond. Ties to family are a particularly important protector against trauma in children, functioning as a means of addressing childrens' sense of helplessness. In these situations, the breakdown of social networks, relationships, and institutions becomes a trauma in itself. "The social body (Scheper-Hughes & Lock, 1987) or collective unconscious (Jung, 1969) becomes the site of the collective trauma" (Somasundaram, 2014, 45). Wilson (2004) supports Somasundaram in using a Jungian perspective to access this, referring to an unconscious manifestation of the collective trauma in terms of an archetype.

Moreover, in non-western settings, seeking help from a counselor or therapist may be seen as inappropriate (Yeh, Arora and Wu, 2006). And cognitive behavioral therapy (CBT), the most highly regarded form of therapy for PTSD in the west, is probably not useable in non-western countries where individual therapy is not feasible. (Wilson, 2007; de Jong, 2011; cited in Somasundaram, 2014). Both these factors argue for different forms of intervention.

Should trauma be defined by a medical model? If not, how do we capture it? To whose advantage is our representation of the traumatized? Muldoon & Lowe (2012) argue PTSD is a form of neo-imperialism because it makes use of a frame that is not relevant to non-western, collectivist cultures. Pathologizing war-affected populations makes interventions more likely, they argue, but fails to capture the normality of a PTS response (Spitzer, 2007 and Summerfield, 2001; cited in Muldoon & Lowe, 2012;) and could have a shaming effect.

As a result of a wealth of research correlating with the above, we now see a growing consensus about looking at wider social dimensions in order to design appropriate interventions. (Harvey, 1996; de Jong, 2002; Psychosocial Working Group, 2003; Landau & Saul, 2004; Hoshmand, 2007; Macy et al. 2004, cited by Somasundaram, 2014). These go beyond just making sure that social institutions, e.g. schools, get restored quickly. "Psychosocial interventions" use group interventions where sharing of problems, community dialogue, traditional healing rituals, art projects, theater initiatives, interpersonal skills development, and training in human rights and mediation are the tools. These endeavors emphasize the link between psychological experience (thought, emotion ad behavior) and wider social experience (relationships, traditions, norms, culture. (Hamber and Gallagher, 2015.)

**Post-conflict societies**

Research on conflict societies generally shows that PTSD is higher in post-conflict societies than in societies with ongoing conflict, (DeJong, Comproe & Van Ommeren). In Northern Ireland, for example, suicide rates rose after the conflict and are notably elevated compared to the rest of the UK, and show that to a considerable degree young men are the demographic group that elevate these numbers (Commission for Victims and Survivors, 2015).

*Safety remains a core issue*

Research in the post-conflict Balkans tells us the factor most associated with PTSD and depression is the fear and loss of control associated with an ongoing perceived threat from those responsible for a trauma. (Bosoglu, et al, 2005) found that once survivors of human rights abuses were in a safe place they were unlikely to develop PTSD. The authors do not elaborate on the nature of the "safe place" and the degree to which safety is a matter of perception over and above someone else's "objective" reality. They simply say that interventions that enhance a sense of control over feared situations are the ones most likely to diminish PTSD. This finding, when placed in juxtaposition to the idea that PTSD emerges more after the conflict is over, suggests that people's sense of safety (their assessment of safety) may initially *diminish* after the conflict ends. More research is clearly needed to understand this. It could mean that mental blockages, or other forms of dissociation that a person puts up during a conflict, get relaxed when the ceasefire comes. Or it could mean that in deeply divided societies like the Balkans, people actually feel

more emotionally intact, or more connected to their own community, when they are engaged in the war than when they are trying to make peace.

Brunéus (2008), reporting on research on women in Rwanda who publicly testified in *gacaca* courts, says that for some, the experience greatly reduced their sense of safety by bringing them to the attention of predators from the opposing group. This is a reminder that in a society where the deep emotions of the conflict remain rife, those who testify publically could undergo persecution by people of the other group. The women in the study reported heart-rending occurrences following their testimony – destruction of their homes, stones being thrown at their windows, cows being brought to graze on their land. Men came and propositioned them and threatened them through the keyholes of their locked doors. Several told how their complaints of security threats were not taken seriously by the authorities.

*"Victims" and agency*

Because trauma is so connected with the individual's awareness of an inability to act to help her or himself, the notion of agency is at the heart of trauma. One question is whether helping a person to find agency is enough to remove trauma symptoms, or whether it is a necessary but not sufficient element of healing. This the answer to this question might play out differently with regard to individual trauma or collective trauma.

Reflection on the South African Truth and Reconciliation Commission (TRC), and particularly the work of the Center for the Study of Violence and Reconciliation which gave professional psychology support to the TRC, has highlighted the need for new thinking on the traumatized person's relation to the larger society. An extension of that discussion is If empowerment is one aspect of the healing process in a society that has been profoundly undermined, where should that empowerment come from? We generally recognize that efforts to assist a community to regroup and find empowerment are not going to work as a top down process. Hamber and others argue that neither is it going to work as a process that occurs only within an individual. It must be a group process building on active participation. (Hamber, 2009)

In recent years the word "victim" in relation to group trauma has been coupled with the word "survivor" to help overcome the connotation of helplessness the word "victim" suggests, and instead emphasize the resilience that such people have shown. In Northern Ireland, for example, a government-formed commission to address the needs of victims is called *The Commission on Victims and Survivors*.

*Transgenerational trauma*

Research coming from a number of directions underlines that trauma is experienced by subsequent generations as yet unborn at the time the traumatic events took place. "Massive trauma shapes the internal representation of reality of several generations, becoming an unconscious organizing principle passed on by parents and internalized by

their children." (Danieli, 2007) Epigenetics and neuroscience now add layers of understanding to Danieli's proposition.

For the decade and a half following the NI conflict, victims were generally considered to be people who were wounded, or the next of kin of the dead. One problem is that has now been acknowledged is that the term "victim" tends to suggest that the impact of the conflict is more limited than it really is. A different way of thinking about the impact of the conflict that is now coming onto the table is to describe the long term social effects of the conflict (Elizabeth Gallagher & Brandon Hamber, 2012) or its transgenerational effects.

Transgenerational effects include epigenetic risks, where parents transmit stress-triggered and stress-adapting genes; relational and attachment problems that children have when their parents are suffering the effects of trauma, which in turn leave children with inadequate experiences of compassion and empathy and ill equipped to emotionally regulate themselves; developmental problems of children in homes where there is violence; increased risk of mental health problems in those who experienced trauma and transmission of these problems to further generations (Commission for Victims and Survivors, 2015). Social psychological impacts include the sociocultural perpetuation of a persecuted ethnic identity based on chosen traumas (Volkan, 1997) and communal memories (Wessells & Strang, 2006).

All of the above can contribute to new episodes of organized violence. (Commission for Victims and Survivors, 2015).

Research on transgenerational (sometimes referred to as intergenerational) trauma has burgeoned in recent years. (Dekel, & Goldblatt, 2008. Downes, Harrison, Curran, & Kavanagh, 2013. Hanna, Dempster, Dyer, Lyons, & Devaney, 2012. Harkness, 1993. Katz, 2003. Lev-Wiesel, 2007. Lin, Suyemoto, & Nien-chu Kiang, 2009. McNally, 2014. Olema, Catina, Ertl, Saile, & Neuner, 2014. Roth, Neuner, & Elbert, 2014. Roth, Neuner, & Elbert, 2014. Sailea, Ertl, Neuner, & Catania, 2014. Scott, & Copping, 2008. Weingartan, 2004.)

**Group trauma and collective memory**

A related literature that is rarely cited by those in the therapeutic community addressing collective trauma is work on collective memory – how it is formed, how it solidifies group identifications, how it feeds off a negative "other," and how the collective memory exacerbates traumatic experience and can undermine the capacity to heal. While group membership can be a source of support for healing in the aftermath of trauma (Lev-Wiesel, 2007), awareness of group persecution or tragedy can be multiplied by the sheer numbers in the particular group. Volkan (1997) describes how an event in the group history that becomes a defining trauma for the group supplies a core construct in the sense of self of an individual.

An example of this can be seen in Northern Ireland in a deadlocked discourse over the definition of the term "victim." Those on the Unionist-Protestant side, whose families were highly represented in the police and the military that had the job of maintaining civil order during the conflict, see their family members who perished in the conflict, and themselves as next of kin, as the only "true" victims, whereas those on the Republican-Catholic side who are bereaved, are, they claim, not legitimate victims because their people were conducting a civil rebellion. It has been suggested that this rigid claim grows from the fact that the families of the police and the military were traumatized in ways that have not been fully acknowledged. (Dawson, 2003, 131)

**Testimony**

The past feeds trauma in several ways. On the one hand, traumatic memories can dominate the lives of those who have suffered trauma to the point that they cannot focus on anything else. "When you can't be fully here, you go to the places where you did feel alive – even if those places are filled with horror and misery." (van der Kolk, 73).

For others, silence provides a refuge, but can also be problematic on the long term. Balkan women who remained silent after rape for fear of being shunned for transgressing acceptable behavior were more likely to show post traumatic stress. (Kellezi et al, 2009; Skheksbaejm 2006; cited in Muldoon & Lowe, 2012)

In cases of traumatized individuals in the west, the psychiatric profession tells us that not all ways of telling a person's story are therapeutic (Herman, 1997). For, beyond telling the story in order to gain acknowledgement for what happened, it is crucial for the person to let her or himself know how they actually felt – to feel the sensations – and to forgive themselves for submitting in order to overcome a sense of shame. Van der Kolk (2014, 233) underlines the difference between giving a logical account of the traumatic events and feeling the feelings. Giving a logical account leads the traumatized person to focus on the listener's opinion about the story she is telling, he says. This process supports one's sense of self across time; it creates meaning. But it can be very susceptible to the mindset of the hearer. On the other hand, it is the "self in the present moment" that is the system that must be "accessed, befriended and reconciled." (van der Kolk, 236) (See also Herman, 1997)

Van der Kolk's above point is rarely made in discussions of "testimony" in collective settings. In a group setting, an individual's testimony will very likely reinforce the group narrative, for the reasons van der Kolk outlines above. This could reinforce the individual's sense of solidarity with the group. But is this a wholly positive outcome? It might get in the way of a truly therapeutic experience for the individual. Moreover, testimony that serves the solidarity of the group may introduce a hardening of group boundaries, exacerbating negative perspectives of the opposing group that could help to reintroduce the conflict.

Indepth interviews of thirty black South African survivors who testified in the TRC indicate that about a quarter experienced it as a positive and "relieving" experience but

the rest actually experienced testifying as painful and disempowering. Twelve felt they gained new information that they appreciated having. About half say that expecting to hear the truth and then not hearing it was difficult to handle emotionally (Byrne, 2004).

In spite of concerns raised about the appropriateness of talk therapy in non-western contexts, talk therapy, intrinsically private, might still have validity and usefulness in such settings. Narrative Exposure Therapy, which involves getting the client to speak repeatedly about the worst traumatic event he or she has experienced while re-experiencing all emotions associated with that event, has been used to good effect in non-western settings (Onyut et al., 2005).

**Conclusion**

While we now have broad recognition that trauma has a collective aspect, and that the traumatic events experienced by an individual need to be understood with regard to their context, a broad range of related questions invite further exploration.

In the field of political psychology, collective memory is generally painted as a product of top-down efforts to establish a narrative that supports the existing power structure. Collective trauma connects with this dynamic in several ways. The oppressive societal narrative may try to marginalize the group who has been traumatized, excluding them from the narrative minimizes the nature of the original trauma and retraumatizes. Dissemination of a collective memory from the top can therefore be a traumatizing exercise.

At the same time, "testimony," on the part of a traumatized group can itself be only a partial cure, because a person who has been traumatized will only gain partial benefit from the liberational group testimony. That person also requires an opportunity to feel within their body the feelings that occurred in the original traumatization. This individual-focused approach might be dismissed as a western model, but in fact it resonates with eastern meditation practices that also advocate awareness of feeling as a way to develop resilience.

As we probe the link between group trauma and long term intractability, we find ourselves confronting a paradox where we see that what is "therapeutic" for the group – tightening group bonds through rhetorical processes that solidify collective memory – might undermine an individually defined process of healing from the brain event that is the essence of trauma. Moreover, the collective memory of the "chosen trauma" is likely to contain negative projections on the "other," or enemy group, locking people into unhealthy self-representations.

**References**


Abramowitz, S. A. (2005). The poor have become rich and the rich have become poor: Collective trauma in the Guinean Languette. *Social Science & Medicine* 61, 2106-2118.

Basoglu, Metin, et al. (2005). Psychiatric and cognitive Eeffects of war in Former Yugoslavia: Association of lack of redress for trauma and posttraumatic stress reactions. *Journal of the American Medical Association*, 294, 5, 580-592.

Bloom, S. (1998). By the crowd they have been broken, by the crowd they shall be healed: The social transformation of trauma. In: R. G. Tedeschi, C.L. Park & L.G. Calhoun (Eds.), *Posttraumatic growth: Positive changes in the aftermath of crisis.* Malwah, NJ: Lawrence Erlbaum Associates, Inc.

Bronfenbrenner, U. (1979) *The ecology of human development.* Cambridge, MA: Harvard University Press.

Brounéus, K. (2008). Truth-telling as talking cure? Insecurity and retraumatization in the Rwandan gacaca courts. *Security Dialogue* 39, 1, 55-76.

Byrne, C. (2004). Benefit or burden: Victims' reflections on TRC participation. *Peace and Conflict: Journal of Peace Psychology* 10, 3, 237-256.

Commission for Victims and Survivors. (2015). Towards A Better Future: The Trans-generational Impact of the Troubles on Mental Health. Report prepared by Ulster University.

Danieli, Y. (2007). Assessing trauma across cultures from a multigenerational perspective. In: J. P. Wilson & C.S.-K. Tang (Eds.), *Cross-cultural assessment of psychological trauma and PTSD* (65-90). New York: Springer.

Dawson, Graham. (2003). Mobilization memories: Protestant and Unionist victims' groups and the politics of victimhood in the Irish peace process. In Paul Gready (Ed.), *Political Transition: Politics and Cultures* (127-147). London: Pluto Press.

De Jong, J. (2002). Public mental health, traumatic stress and human rights violations in low-income countries: A culturally appropriate model in times of conflict, disaster and peace. In: J. de Jong (Ed.), *Trauma, War and Violence: Public mental health in sociocultural context* (1-91). New York: Springer.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition: DSM-5.

Erikson, K. (1976). Disaster at Buffalo Creek. Loss of communality at Buffalo Creek. *American Journal of Psychiatry,* 133, 3, 302-305.

Erikson, K. (1979). *In the Wake of the Flood.* London: Allen Unwin.

Hamber, Brandon. (2009) *Transforming Societies After Political Violence: Truth, Reconciliation and Mental Health*. Springer.

Hamber, Brandon & Gallagher, Elizabeth. (2015). Addressing the psychosocial needs of young men: the case of Northern Ireland. In: Brandon Hamber, & Elizabeth Gallagher, (Eds.) *Psychosocial Perspectives on Peacebuilding.* Springer.

Hart, Barry, (Ed.) (2008). *Peacebuilding in Traumatized Societies*. Lanham, MD: University Press of America, Inc.

Harvey, M. R. (1996). An Ecological View of Psychological Trauma and Trauma Recovery. *Journal of Traumatic Stress* 9(1), 3-23.

Herman, Judith. (1997) *Trauma and Recovery.* New York: Basic Books.

Hoshmand, L.T. (2007). Cultural-ecological perspectives on the understanding and assessment of trauma. In: J. Wilson & C.S.-K. Tang (Eds.) *Cross Cultural Assessment of Psychological Trauma and PTSD* (31-50). New York: Springer.

Johnson, H. & Thompson, A. (2008). Development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: A review. *Clinical Psychology Review* 28, 1 (January 2008), 36–47.

Jung, G. G. (1969). *The Archetypes and the Collective Unconscious.* Princeton: Princeton University Press.

Kellezi, Blerina, Reicher, Stephen, & Cassidy, Clare. (2009). Surviving the Kosovo Conflict: a study of social identity, appraisal of extreme events, and mental well-being. *Applied psychology* 58, 1, 59-83. DOI: 10.1111/j.1464-0597.2008.00382.x

Krieg, Anthea. (2009). The experience of collective trauma in Australian indigenous communities. *Australasian Psychiatry* Supplement 1, 17, S28-S32.

Landau, L. & Saul, J. (2004). Facilitating family and community resilience in response to major disaster. In: F. Walsh & M. McGoldrick (Eds.), *Living Beyond Loss* (285-309). New York: W. W. Norton & Company.

Macy, R.D., Behar, L., Paulson, R., Delman, J., Schmid, L. & Smith, S.F. (2004). Community-based, acute post-traumatic stress management: a description and evaluation of a psychosocial intervention continuum. *Harvard Review of Psychiatry*, 12, 217-228.

Muldoon, Orla T. & Lowe, Robert D. (2012). Social identity, groups, and post-

traumatic stress disorder. *Political Psychology*, 33, 2, 259-273.

Nordanger, D. (2007a). Coping with loss and bereavement in post-war Tigray, Ethiopia. *Transcultural Psychiatry* 44, 545 DOI: 10.1177/1363461507083896

_____. (2007b). Discourses of loss and bereavement in Tigray, Ethiopia. *Culture, Medicine and Psychiatry, 31*, 2, 173–194.

Psychosocial Working Group (2003). *Psychosocial Intervention in Complex Emergencies: A Conceptual Framework*. University of Edinburgh. Edinburgh: Psychosocial Working Group.

Schedper-Hughes N. & Locke, M.M. (1987). The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly,* 1, 1, 6-41.

Skjelsbsk, I. (2006). Victim and survivor: Narrated social identities of women who experienced rape during the war in Bosnia-Herzegovina. *Feminism & Psychology*, 16, 373-403.

Somasundaram, Daya. (2007). Collective trauma in Sri Lanka. *International Journal of Mental Health Systems, Psychosocial Work & Counseling in Areas of Armed Conflict* 1 (1).

_____. (2014). Addressing collective trauma: conceptualisations and interventions. *Intervention* 12, Supplement 1, 43-60.

Spitzer, R. L., First, M. B.. & Wakefield, J. C. (2007). Saving PTSD from itself in DSM-5. *Journal of Anxiety Disorders*, 232-241.

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *British Medical Journal*, 322, 95-98

Tajfel. H. (1974). Social identity and intergroup behaviour. *Social Science Information*, 14, 101-118.

_____. (1981). Human groups and social categories. Cambridge: Cambridge University Press.

Tajfel, H. & Turner, J. C. (1986). The social identity theory of intergroup theory. In S. Worchel & W. G. Austin (Eds.), *Psychology of intergroup relations* (7-24). Chicago: Nelson Hall.

Van der Kolk, Bessel. (2104). *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma*. New York: Viking.

Volkan, V.D. (1997). *Bloodlines: From ethnic pride to ethnic terrorism.* New York: Farrar, Straus & Giroux.

Wessels, M. & Strang. A. (2006). Religion as resource and risk: The double-edged sword for children in situtions of armed conflict. In: N. Boothby, A. Strang & M. Wessells, (Eds.), *A world turned upside down – Social ecological approaches to children in war zones* (199-222). Bloomfield, CT. Kumarian Press.

Wilson, J. (2004). The broken sprit: Posttraumatic damage to self. In: J. Wilson & B. Drozdek (Eds.), *Broken Spirits – The treatment of traumatized asylum seekers, refugees, war and torture victims* (109-158). New York: Burnner-Routledge.

Wilson, J. (2007). The Lens of culture: Theoretical and conceptual perspectives in the assessment of psychological trauma and PTSD. In: J. Wilson & C.S.-K. Tang (Eds.), *Cross-Cultural Assessment of Psychological Trauma and PTSD* (3-30). New York: Springer.

Yeh, C., Arora, A. & Wu, K. (2006). A new theoretical model of collectivistic coping. In: P. Wong & L. Wong (Eds.), *Handbook of Multicultural Perspectives on Stress and Coping* (56-62). New York: Springer.

**References relating to Transgenerational or Intergenerational Trauma**

Dekel, R. & Goldblatt, H. (2008). Is there intergenerational transmission of trauma? the case of combat veterans' children. *American Journal of Orthopsychiatry, 78, 3*, 281- 289. doi: 10.1037/a0013955

Downes, C., Harrison, E., Curran, D., & Kavanagh, M. (2013). The trauma still goes on.... the multigenerational legacy of Northern Ireland's conflict. *Clinical Child Psychology and Psychiatry* 18, 4, 583-603. doi: 10.1177/1359104512462548

Hanna, D., Dempster, M., Dyer, K., Lyons, E., & Devaney, L. (2012). *Young people's trans-generational issues in Northern Ireland*. (A Report for the CVSNI) Belfast: QUB, School of Psychology.

Harkness, L. L. (1993). Trans-generational transmission of war-related trauma. In J. P. Wilson & B. Raphael (Eds.), *International Handbook of Traumatic Stress Syndromes* (635-643). New York: Plenum Press.

Katz, M. (2003). Prisoners of Azkaban: understanding intergenerational transmission of trauma due to war and state terror. *Journal for the Psychoanalysis of Culture and Society, 8, 2*, 200-207. doi: 10.1353/psy.2003.0037

Lev-Wiesel, R. (2007). Intergenerational transmission of trauma across three generations. *Qualitative Social Work, 6*, 75-94.

Lin, N. J., Suyemoto, K. L., & Nien-chu Kiang, P. (2009). Education as catalyst for intergenerational refugee family communication about war and trauma. *Communication Disorders Quarterly, 30, 4,* 195-207.

McNally, D. (2014). Trans-generational trauma and dealing with the past in Northern Ireland. WAVE Trauma Centre. Retrieved online from http://www.wavetraumacentre.org.uk/uploads/pdf/1404220890--100105-WAVE-transgen-report.pdf

Olema, D.K., Catina, C., Ertl, V., Saile, R., & Neuner, F. (2014). The hidden effects of child maltreatment in a war region: correlates of psychopathology in two generations living in Northern Uganda. *Journal of Traumatic Stress, 27,* 35-41. doi: 10.1002/jts.21892

Roth, M., Neuner, F., & Elbert, T. (2014). Trans-generational consequences of PTSD: risk factors for the mental health of children whose mothers have been exposed to the Rwandan genocide. *International Journal of Mental Health Systems, 8 (12)*, 1-12. doi:10.1186/1752-4458-8-12

Sailea, R., Ertl,V., Neuner, F., & Catania, C. (2014). Does war contribute to family violence against children? findings from a two-generational multi-informant study in Northern Uganda. *Child Abuse & Neglect, 38*, 135–146. doi: 0.1016/j.chiabu.2013.10.007

Scott, K, L. & Copping, V. (2008). Promising directions for the treatment of complex childhood trauma: the intergenerational trauma treatment model. *The Journal of Behaviour Analysis of Offender and Victim Treatment and Prevention, 1(3)*, 273-288.

Weingartan, K. (2004). Witnessing the effects of political violence in families: mechanisms of intergenerational transmission and clinical interventions. *Journal of Marital and Family Therapy, 30,1*, 45-59.