

A THEMATIC ANALYSIS OF PARTICIPANT EXPERIENCE IN THE HEALING OF
MEMORIES COLLECTIVE, SUBCLINICAL TRAUMA TREATMENT

A dissertation submitted to
the Wright Institute Graduate School of Psychology, in partial fulfillment
of the requirements for the degree of Doctor of Psychology

by
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JULY 2011

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July 2011

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This study explores the experience of participants in a Healing of Memories (HOM) workshop to assess its efficacy as an intervention for facilitating healing from traumatic experience. The HOM workshop was initially designed as a parallel process to South Africa's Truth and Reconciliation Commission to facilitate social and individual healing in the wake of apartheid. It has since been used internationally and with a variety of different contexts to promote healing and reconciliation. Eleven participants from a recent HOM workshop participated in semi-structured interviews that asked them to enumerate their experiences in relation to various aspects of the workshop's structure and process. A method termed content analysis was used to derive relevant themes across subjects.

Major findings indicated that participants chose to enroll in the HOM workshop for a variety of reasons. In describing the components of the model, participants reported that expressive arts activities, rituals, and storytelling helped facilitate the release of negative emotions by encouraging a deepening of emotional experience, creating a context for individual experiences, and supporting reflection about the individual's life. Participants also identified the following processes as particularly therapeutic: the formation of intimate connections, the facilitation of empathy for the experiences of others, and the validation of one's own experiences through the process of mutual witnessing. All study participants reported positive feelings about their experience in the HOM workshop, and described the subtle yet profound nature

of the shifts and/or changes they believed took place as a result of their participation. In general, participants expressed an appreciation for the simplicity and accessibility of the HOM workshop model and a curiosity about how its interventions could be applied in other contexts.

Dedication

To my grandparents
Mitch and Susi Davidovitz

This is the duty of our generation as we enter the twenty-first century— solidarity with the weak, the persecuted, the lonely, the sick, and those in despair. It is expressed by the desire to give a noble and humanizing meaning to a community in which all members will define themselves not by their own identity but by that of others.

— Elie Wiesel

Acknowledgments

This dissertation would not have been possible had it not been for my dissertation committee. I would like to express my deepest gratitude to my dissertation chair, Dr. Jerry Diller who went above and beyond his role as a committee member to help me reach my goals. His guidance, knowledge, and insight were paramount to me in this process and I will be forever grateful for his generosity of wisdom and time. I would also like to thank my reader, Dr. Anne Grenn Saldinger, for her support, encouragement, flexibility, and willingness to be available to me despite all that she had going on in her personal life.

To my family and friends, thank you for your encouragement, devotion, and understanding during these long years of my education. To my dad, Morey, thank you for your endless emotional support, unconditional love, and for believing in me even when I felt I had nothing more to give. To my mom, Donna, one of the best therapists I know, thank you for spending all those long nights with me throughout graduate school editing and brainstorming ideas for papers despite having already gone through the process once yourself. I feel so fortunate to be following in your footsteps and could not have asked for a better role model in the field.

To my sister Lisa, thank you for your friendship, understanding, humor, and willingness to be my comic relief at all hours of the day and night. To my husband Shawn, thank you for being the voice of reason that not only helped to keep me sane but also sacrificed so much to help me succeed. I cannot put into words what your love and support has meant to me over the past four years. Thank you for pushing me to reach my

full potential. I would not have been able to accomplish all that I have had it not been for you always standing by my side.

I would especially like to thank Ginny Morgan for her prompt responses to my endless stream of questions throughout this process and Holly Schneider for her willingness to be a second coder and for providing invaluable data analysis consultation on this project.

Lastly, thank you to the Wright Institute community and all the teachers and students who provided me with an invaluable education. I feel so fortunate to have had the opportunity to learn from such amazing people.

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Chapter I: Introduction

Trauma cannot be ignored. It is an inherent part of the primitive biology that brought us here. The only way we will be able to release ourselves, individually and collectively, from re-enacting our traumatic legacies is by transforming them through renegotiation. Whether we choose to transform these legacies through group experiences, shamanic practices, or individually, it must be done. (Levine, 1997, p. 232)

This dissertation was inspired by my own experience of being the granddaughter of Holocaust survivors. From a very young age, I was fascinated by the different ways my relatives shared their traumas of surviving the concentration camps. Some acknowledged past experiences with an outpouring of tears and anger, while others would recall only parts of their experience in a disconnected and factual manner. Still others would be silent and look away whenever the topic of the Holocaust would arise in conversation. Some identified themselves as victims while others classified themselves as survivors. While dissociation, depression, and isolation are all normal responses to traumatic stress, it was interesting to see how these different responses impacted my relatives' sense of self, interpersonal relationships, and connection to the Jewish community as well as the greater secular society.

As a teenager, I was struck by my father's reluctance to discuss his parents' experience with them despite his fascination with the events of World War II. I then became curious about the intergenerational transmission of trauma and how the impact on my father's generation might impact my own. Specifically, I became aware of my own preoccupation with world events where individuals and/or communities were discriminated against or annihilated due to differences in class, race, and religious beliefs. As an adult, although I was fortunate enough to have not directly experienced significant trauma, I recognized that I was quite hypervigilant and could quickly become filled with

anxiety when witnessing direct discrimination, anti-Semitism, and abuses of power. I wondered if this hypervigilance might be related to unconscious internalized trauma inherited from my ancestors. This curiosity about trauma transmission along with my desire to heal led me to participate in a Healing of Memories (HOM) workshop wherein I was able to reflect on my own experience as it related to the horrors my ancestors had experienced. Through the development and creation of my own narrative, I began the process of incorporating my family's complex and traumatic history into my own experience and identity as a third-generation Holocaust survivor.

Purpose of Study

Only a few studies have explored the effectiveness of HOM workshops. These studies have found these workshops to be helpful; however, little is known about the specific aspects of the workshops especially what participants find central to their healing experience.

The participants in this current study attended a 2-day HOM workshop, and this study will explore the workshop's impact on their healing process in relation to the traumatic experiences they chose to explore. Using a qualitative research methodology, this study will look for common themes and provide a detailed description of these themes in order to offer some meaningful explanations for the various changes and shifts that may have occurred during the workshop. In doing so, this study will not only provide empirical support for the efficacy of the HOM model, but also highlight the aspects of the workshop that the participants found most impactful on their integration and healing of traumatic experiences.

Statement of Problem

According to Solomon and Davidson (1997), traumatic events are fairly common. Based on the findings of their research, they asserted that most Americans will experience at least one traumatic event and that approximately 5% of men and 10%-12% of women will suffer from PTSD at some point over the course of their lives. In a community epidemiologic study conducted by Breslau, Kessler, Chilcoat, Schultz, Davis, and Andreski (1998) assessing trauma exposure, they found that 90% of participants reported exposure to at least one traumatic life event. Trauma has become so commonplace, however, despite these overwhelming statistics, that PTSD is largely unrecognized. In fact, according to the National Comorbidity Study conducted by Kessler, Sonnega, Bromet, Hughes and Nelson (1995), 60% of people with PTSD go untreated. As long as interpersonal and societal violence persists, there will continue to be a great need for interventions aimed at addressing trauma-related symptomatology and PTSD.

The prevalence of exposure to traumatic events is more common than was originally anticipated when the diagnosis of Posttraumatic Stress Disorder (PTSD) was proposed as a diagnostic category in 1980 (Keane, Marshall, & Taft, 2006). In fact, PTSD is reported to be the fifth most common psychiatric condition in the U.S. (Kessler, Berglund, Demler, Jin, & Walters, 2005). Many people are exposed to potentially traumatic experiences and present with trauma related symptomatology without necessarily meeting the criteria for PTSD. The term *subclinical traumatization* can be used to describe the experience of such individuals who carry no formal PTSD diagnosis

yet continue to be impacted by trauma-related symptoms whereby the general quality of their life functioning is in various ways impacted.

With continued interpersonal violence, global conflict, and uncontrollable natural disasters, it is crucial to identify useful interventions for trauma treatment and healing. It is believed that the HOM model is an effective trauma treatment intervention that can be useful for treating individuals and communities who have endured traumatic experiences and present with varying degrees of symptomatology.

Trauma itself has been widely studied, and many studies have demonstrated the psychological, social, and neurobiological impact of trauma. However, much is still unknown about its effects due to its complexity, the variety of individual and cultural responses to traumatic incidents, and resiliency factors. Trauma can be quite multifaceted, impacting individuals, communities, and larger societies either directly or indirectly via transgenerational transmission (which is of particular interest to this study).

Most traditional trauma treatments focus on treating the individual's symptomatology in individual therapy. In Judith Herman's (1997) model of trauma treatment, she identified three stages one must successfully move through in order to address the existing pathological symptomatology: the establishment of safety, remembrance and mourning, and restoring connections. Although Herman's model focused on individual treatment, she strongly emphasized the importance and efficacy of group treatment modalities in addressing the social relational dimensions of trauma (Herman, 1997).

Across therapeutic modalities, a central theme in the treatment of trauma survivors is their inability to form narratives of their traumatic experiences. Treatment, if

successful, will assist with the processing of such experiences and help to reduce and or eliminate posttraumatic stress symptoms (Mollica, 1988; van der Kolk & van der Hart, 1991; Wigren, 1994). Wigren (1994) emphasized the importance of narratives to psychological organization, and his work included helping traumatized individuals contain and process past experiences and affects. Additionally, narratives provide the language that enables connections to be formed between thoughts and feelings, and they are, therefore, essential to social exchange (Wigren, 1994).

The Institute for Healing of Memories was initially developed in response to South Africa's Truth and Reconciliation Commission (TRC). The purpose of the Institute was to provide South Africans who had been unable to appear before the TRC an opportunity to share their experiences and have their suffering acknowledged. While initially developed to address trauma related to apartheid oppression, the Healing of Memories (HOM) model has been useful in addressing traumatic experience in a variety of different contexts and communities.

The HOM workshops seek to create a safe space wherein a collective or group of individual participants from varied backgrounds can come together to share their trauma-related stories in a narrative form. The focus of this experience is the participants' emotional response, or affect, rather than an intellectual understanding of the content of their trauma. The workshop model assumes that emotional healing is achieved through the experience of story-telling as well as being listened to and having one's experience acknowledged and witnessed by others. In this way, the narrator is able to release painful feelings associated with the past. Furthermore, through the experience of bearing witness

to the experiences of others, empathy and mutual understanding are promoted, which can then lead to reconciliation and help restore connections to others in one's community.

Rationale for the Study

There is no lack of empirical research in trauma-related literature regarding interventions and treatment approaches. However, due to the complex nature of trauma—as well as the variation of individual responses to traumatic experiences—comparisons of behavioral, psychodynamic, psychopharmacologic, and group narrative therapies have not been adequately addressed (Hanson, Kilpatrick, Freedy, & Saunders, 1995; van der Kolk & Fisler, 1995). This research will evaluate the HOM as a collective treatment process that may help subclinical victims of traumatic experience better cope and move forward with their lives. Through the identification and qualitative exploration of various themes, it is hoped that the impact of this workshop model will be more clearly understood, and therefore, will be useful in administering such interventions in the future with similar populations.

Significance of the Study

The literature is sparse regarding the evaluation of collective or community-based treatment models as well as narrative, experiential, and group therapy approaches. Yet, participants in collective approaches such as the HOM workshop, the focus of the present research, have consistently reported that their experience in the workshops “impacted [their] life in a big way” and “shifted something inside of [them].” It is therefore crucial to determine, more specifically, the impact of HOM workshops and how they function to promote the healing of trauma. By gaining a deeper understanding of the impact and usefulness of such treatment modalities, therapists and other mental health professionals

can more confidently begin to apply these interventions in their work with individuals and societies who have been exposed to and impacted by trauma.

Chapter II: Review of the Literature

This chapter will address the literature and research topics related to trauma, its treatment, and the HOM workshop model that are relevant to this current study. The chapter is divided into four sections: (a) the definition of trauma, individual versus societal trauma, simple trauma versus complex trauma, and trauma symptomatology; (b) individual, one-on-one trauma treatment models; (c) collective trauma treatment models; and (d) the history, development, and clinical procedures of the HOM model and workshop.

I. Trauma

Definition of trauma. Judith Herman, a psychiatrist, researcher, and author defined trauma or traumatic events by stating that they:

overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning.... Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life.... Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim's faith in a natural or divine order and cast the victim into a state of existential crisis. (1997, p. 51)

Trauma was introduced as a diagnostic category in the third edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III*, American Psychiatric Association, 1997). The diagnosis was labelled posttraumatic stress disorder (PTSD) and it was identifiable by 17 symptoms in three symptom clusters: re-experiencing the trauma, avoidance and numbing, and hyperarousal. The clinical presentation of traumatized individuals can be quite complicated as they often present with guilt, dissociation, alterations in personality, affect

dysregulation, and difficulties in intimacy and attachment (Herman, 1997). In addition, trauma can impact an individual cognitively, emotionally, physically, and behaviorally, and it may contribute to the development of significant anxiety, depression, phobias, or panic disorders (van der Kolk, McFarlane, & Waisaeth 1996). Thus, individual responses to trauma may vary in complexity and symptomatology.

As previously stated, many individuals who have experienced trauma present with diminished functioning yet do not meet the criteria for a formal PTSD diagnosis. Trauma symptoms can also remain dormant for years following a triggering event and as a result, may go unrecognized. For these reasons, many trauma victims can appear asymptomatic or be labeled as psychosomatic (Levine, 1997). However, over time, unaddressed symptoms can accumulate. When faced with stress or in the presence of another traumatic incident, these symptoms can suddenly appear without warning and may lead to a breakdown. Treatment is therefore crucial regardless of the presence or degree of symptomatology.

Individual versus collective trauma. Individual psychic trauma is trauma resulting from the actions of an individual perpetrator. It can be characterized by one person's unique experience of an event, which often presents a danger to one's life or body integrity, and this event overwhelms the individual's ability to integrate his or her emotional experience of the event (Herman, 1997). The individual experiences feelings of terror and helplessness. Examples of such individual traumas include abuse, physical assault, serious bodily harm, or the witnessing of serious injuries or fatalities.

Societies are also susceptible to stress and trauma in much the same way as individuals. Levine (1997) explained that just as traumatized individuals are susceptible

to re-enacting trauma, trauma has the potential to be re-enacted on a societal level in the form of violence. *Social trauma* can be defined as trauma that results from violence directed toward a social group. Examples include conflict, war, genocide, racism, torture, enslavement, and revolution (Diller, 2011). These populations are often targeted due to differences in race, ethnicity, gender, sexual orientation, or socioeconomic status. Social trauma can impact individuals and communities as well as future societies through *transgenerational transmission*. As previously stated, this term refers to traumatic stress that is passed down either directly or in the form increased susceptibility to potential traumatizing stimuli, to future generations, including children and other subsequent relatives, in the form of anxiety, depression, or unspoken thoughts or fantasies that compromise the psychosocial health of subsequent generations (Baranowsky, Young, Johnson, Douglas, Williams-Keeler, & McCarrey, 1998; Gutlove & Thompson, 2003; Kellermann, 2001).

Sociologist Kai Erikson asserted that *social trauma* results in the impairment of a community and causes a “blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of community” (1994, p. 233). Often, social trauma results in what is known as *psychosocial degeneration* wherein an entire population may lose its faith or trust in its own society or the larger global society (Gutlove & Thompson, 2003).

Simple versus complex trauma. Herman (1997) argued that there is a distinct difference between individuals who have experienced a single trauma and those who have experienced prolonged exposure to trauma, such as continual abuse, torture, or domestic violence. Herman argued that the diagnosis of PTSD does not capture the

complexities of repeated trauma, which may include personality changes and diminished relatedness and identity. Herman proposed a separate diagnosis of Complex PTSD for those who have suffered prolonged exposure to trauma, in so doing, introduced the concept of understanding or defining trauma on a spectrum rather than as a single disorder. The American Psychiatric Association has decided to add Complex PTSD to the upcoming *DSM-V*, and the Association is also considering additional conceptualizations of PTSD, such as Complex Trauma DES (Disorder of Extreme Stress) (Herman, 1997; van der Kolk et al., 1996).

Impact of trauma and trauma symptomatology. Trauma has significant cognitive, physiological, and psychological consequences. Individuals with PTSD often present with interpersonal difficulties related to interpersonal skills, the quality of their relationships and interconnectedness with others, and interpersonal withdrawal (Okey, McWhirter, & Delaney, 2000). Early traumatic experiences have been shown to impact development and are associated with a higher likelihood of psychiatric impairment in adulthood (Schottenbauer, Glass, Arnkoff, & Gray, 2008). In addition, trauma can also disturb the healthy development of psychological defenses, which may later impact one's ability to effectively cope with stressful circumstances (Vaillant, 1971) as well as negatively impact one's capacity for reflective functioning and mentalization (Schottenbauer et al., 2008).

Following a traumatic event, an individual may experience PTSD reactions in a number of ways that span behavioral, cognitive, emotional, and physical modalities. Symptoms associated with trauma include, but are not limited to, flashbacks, anxiety, panic attacks, depression, insomnia, psychosomatic complaints, anger outbursts,

destructive behaviors, and lack of openness (Levine, 1997). This wide array of symptomatology associated with PTSD has been categorized in a number of different ways. Herman (1997) highlighted three main symptom categories associated with trauma: hyperarousal, intrusion, and constriction.

Hyperarousal is the first symptom associated with PTSD and is manifested when the individual remains in a permanent state of arousal, alert for the presence of danger or threatening situations. This state can be experienced both during waking moments as well as in sleep states, and it often causes significant sleep disturbances that present as nightmares. Individuals experiencing hyperarousal often feel unsafe and insecure; in their experience of the world, danger is everywhere.

Intrusion refers to the repeated interruption of one's life through the constant re-experiencing of trauma in one's mind. In this stage, the traumatized person relives the traumatic event as if it were happening in the present through flashbacks, vivid bodily and physical sensations, and intrusive images in the form of memories, dreams, or actions. Herman (1997) described traumatic memories as lacking "a verbal narrative and context" (p. 38).

Some early theorists, including Janet (1926) and Freud (1920/1950), speculated that this constant reliving of trauma is a "repetition compulsion" or attempt to master, integrate, or adapt to the traumatic event. Repeated experiences of reliving trauma can be overwhelming and emotionally distressing, and therefore, survivors of trauma often actively avoid experiences that may exacerbate PTSD symptoms and have longstanding negative consequences on their life and relationships (Herman, 1997).

Constriction is another self-defensive stance. In this attempt at self-defense, the survivor goes into a “state of surrender” that involves dissociation or numbing to protect the self from intolerable pain. Through dissociation or numbing, the traumatized individual can keep traumatic experiences away from his or her consciousness. As such, the individual in this state often appears emotionally detached and indifferent. Often, this numbing is achieved through the use of drugs or alcohol, which can eventually lead to substance abuse and dependency.

Although adaptive in moments of danger, these self-protective states can also prevent the integration that is necessary for healing (Herman, 2007). Herman asserted that, although constriction may be protective against overwhelming emotional states, it also narrows the trauma survivor’s quality of life, which, in turn, can perpetuate the effects of the trauma.

Another common response to trauma is silence. According to Herman (1997, p. 1), “The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of the psychological trauma.” The shame and fear following traumatic events often encourages silence, which then may lead to discontinuity and fragmentation, ultimately impacting the victim’s sense of identity (Richman, 2006). In addition, mental activity may shut down, impacting processes of association, symbolization, and narrative formation (Laub, 2005). When one is unable to speak about one’s experience, these memories and experiences become stored in one’s body and often manifest as symptoms or reenactments (Richman, 2006).

The Holocaust literature in particular has highlighted the silence that ensues from mass trauma and the effect of silence on subsequent generations. In addition, the

Holocaust trauma literature has shown that one of the major consequences of trauma is the destruction of empathy that ultimately impacts the victim's ability to establish a link between self and other (Auerhahn, Laub, & Peskin, 1993). Victims tend to believe that others will not be able to understand or empathize with their experience of suffering, and these beliefs are often accompanied by their own difficulty empathizing with others. This "failed empathy" can lead to the victim feeling disconnected, which ultimately impacts the victim's ability to know and get close to others (Richman, 2006).

Herman (1997) emphasized the fascination yet simultaneous discomfort many people feel when confronted with the traumatic experiences of others. Common responses to victims of trauma include avoidance, denial, and discreditation, which often leave the victim feeling devalued and invisible. As a result, they are often socially ostracized or told not to speak of their experience. For example, while conducting interviews with Nazi Holocaust survivors, Danieli (2009) found that survivors' attempts to communicate their Holocaust experiences and continued suffering were largely ignored and not believed by nonsurvivors, including mental health professionals. Many survivors therefore concluded that people who had not gone through similar experiences could not understand them. This led to what Danieli (1984) referred to as a *conspiracy of silence* between Holocaust survivors and society. Danieli (2009) proposed that this conspiracy of silence is the mechanism that contributes to the transmission of trauma, the perpetuation of trauma related symptomatology in subsequent generations.

Herman (1997) also highlighted the impact that trauma can have on one's connection to the community. When faced with trauma, individuals often long for and seek comfort and protection in their attachment relationships with caregivers. When this

need is not met or is unavailable, the trauma survivor may feel abandoned, alienated, or disconnected. These primary attachment relationships with one's caregivers serve as the foundation upon which personality development is fostered, and as such, trauma may have a direct impact on these connections. Over time, if one's caregivers or loved ones do not provide the protection and comfort that the trauma victim needs, the traumatized individual may experience a loss of a sense of self or the reopening of previously resolved developmental conflicts (Herman, 1997; van der Kolk, 1996).

Neurobiological impact of trauma. The central nervous system (CNS) has a biological response to traumatic or overwhelming experiences. Immediately following exposure to a traumatic event or during stressful situations, the stress hormones cortisol, epinephrine, norepinephrine, and oxytocin are secreted (Axelrod & Neisine, 1984). When this occurs, traumatized individuals respond to certain physical and emotional stimuli as if they were continuing to experience the initial threat (van der Kolk & Saporta, 1991). These disruptions often present as hyperarousal, intrusive re-experiencing, numbing and avoidance, affective distress, cognitive distortions, somatization, and dissociation (van der Kolk, McFarlane, & Weisaeth, 1996). Cumulative exposure to stress hormones can cause decreases in serotonin levels, increases in cortisol levels, and significant suppression of hippocampal functioning, the region of the brain responsible for memory (Axelrod & Neisine, 1984; Curnow, 2007; Dupue & Spont, 1989).

Keane and Kaloupek (1982) also noted that traumatized individuals demonstrate overreactive startle responses, noted by increased heart rate, heightened blood pressure, and perspiration. These reactions cause an intensification of emotional reactivity, with a direct response to the stimulus without assessing the cause of the arousal (van der Kolk &

Saporta, 1991). Such reactivity results in a disconnection between affect, thoughts, and behavior. The traumatized individual often dissociates as a psychological defense in an attempt to manage these overwhelming experiences. Amnesia, another common response to dysregulation, results in difficulty recalling specifics related to a traumatic incident although feelings associated with the traumatic event remain. Without the capacity to integrate memories and experiences, these overwhelming feelings then become “encoded on a sensorimotor level without proper localization in space and time” and “cannot be easily translated in the symbolic language necessary for linguistic retrieval” (van der Kolk & Saporta, 1991, p. 204). When expression of these experiences is inhibited, psychophysiological impairment occurs, and the individual may experience physical symptoms, such as stomach pain, tightness in the chest, headaches, and other psychosomatic complaints. When examining the relationship between self-disclosure and health, Pennebaker and Susman (1988) found that the expression of memories and feelings related to a traumatic event helps restore immune function and psychophysiological competence in individuals with trauma histories.

Levine’s (1997) view of trauma emphasized the holistic nature of human beings and stressed the importance of body awareness in the successful treatment of trauma. In order for successful healing of trauma, he believes it is important to understand that traumatic symptoms are both physiological and psychological in nature and not caused by the triggering event itself but rather the “frozen residue of energy that has not been resolved and discharged” (Levine, 1997, p. 19). In his comparison of trauma responses in humans and animals, Levine (1997) asked and addressed the question of why animals in the wild, although threatened routinely, are rarely traumatized and relatively immune to

traumatic symptoms. Despite similarities in the potential for trauma over a lifetime, Levine (1997) believed that humans, unlike animals, have a more difficult time releasing trauma, which results in impairments in one's physical and mental functioning.

Levine (1997) claimed that psychological wounds are reversible and that physical and mental health can be restored through the process of completing instinctive responses to threat and releasing fear-related energy. According to Levine (1997), a person who has experienced a threat must discharge all the energy that was mobilized to negotiate the threat. If this energy is not released, the person risks becoming a victim of trauma as the residual energy then becomes locked within the brain and embedded in the nervous system. Unreleased energy does not disappear but instead persists and forces the formation of various adverse symptoms such as anxiety, depression, and psychosomatic problems as a way for the body to contain the undischarged residual energy.

In order for healing to occur, individuals must go through a 'discharging process' in a safe environment where one's physical instincts can take over (Levine, 1997). Typically, this process is experienced through bodily sensations. Following exposure to a threatening situation humans, like animals, will often spontaneously tremble and shake for an extended period of time. However, often the rational and self-conscious part of the human mind interrupts this process in an attempt to regain control (Levine, 1997). In doing so, the discharge process is prematurely terminated and the trauma energy remains frozen or trapped inside the individual's body. Levine (1997) highlighted how this process of energetic discharge is often seen in shaman healing rituals:

Since precivilization, shamanistic healers from many cultures have been able to successfully orchestrate the conditions that encourage the "lost soul" to return to its rightful place in the body. Through colorful rituals, these so-called "primitive" healers catalyze powerful innate healing forces in their patients.... Significantly,

while the ceremonies themselves vary, the beneficiary of the healing almost always shakes and trembles as the event nears its conclusion. This is the same phenomenon that occurs in all animals when they release bound-up energy. (Levine, 2007, p. 58)

When trauma is successfully renegotiated, the process of transformation can occur.

Through transformation, the individual can regain the capacity to self-regulate and can begin to heal (Levine, 1997).

Herman's theory of trauma and recovery. Herman (1997) identified three stages of recovery from trauma: safety, remembrance and mourning, and reconnection. Although seemingly basic, Herman asserted that her model of trauma is, in fact, an attempt to simplify an often disordered and multifaceted process. Furthermore, Herman stressed that the process of trauma recovery is unique to each survivor, highlighting the often nonlinear process and vacillation that occurs between stages.

The primary task in beginning work with a trauma survivor consists of managing physiological symptoms and establishing safety and trust. This stage can vary greatly from a few days to years, depending on whether the trauma is characterized as acute or chronic. People who have experienced trauma often have difficulty trusting others, and they often feel unsafe in their own bodies. The therapist or helping professional working with the trauma survivor must recognize the importance of this stage in the healing process. If safety is not achieved, the survivor may have difficulty fully committing to treatment, thus affecting progression through the additional stages of recovery (Herman, 1997).

Therapists should first focus on helping trauma survivors gain control over their body before focusing on how a survivor might begin to gain control over his or her

environment. This often entails reducing hyperarousal and intrusive symptoms. During this phase, special attention should be paid to basic health needs, including sleep, exercise, and diet, as well as managing posttraumatic symptoms, and regulating self-destructive behaviors.

Environmental control then includes elements of crisis intervention, including establishing a safe living situation and developing a plan for self-protection. This initial stage requires planning and action on the part of the individual, capacities that have often been undermined by the trauma. In this process, “[the traumatized victim] enhances her sense of competence, self-esteem, and freedom.... She begins to develop some sense of trust in the therapist, based on the therapist’s reliable commitment to the task of ensuring safety” (Herman, 1997, p. 167).

Remembrance and mourning is Herman’s second stage of recovery. In this stage, the survivor begins using words to provide a detailed and complete story of his or her trauma. In doing so, the survivor is actively restructuring his or her traumatic memory into what Mollica (1988) described as a “new story” consisting of dignity and virtue rather than shame and humiliation. Herman stressed the importance of the therapist’s role in this stage, emphasizing that not only is it important for the therapist to bear witness to the survivor’s story, but the therapist also:

normalizes the patient’s responses, facilitates naming and the use of language, and shares the emotional burden of the trauma.... She also contributes to constructing a new interpretation of the traumatic experience that affirms the dignity and value of the survivor. (Herman, 1997, p. 179)

Herman believed that this second stage of recovery is complete when survivors have told their story, and in doing so, have begun to reclaim pieces of their history as well as a newfound sense of hope for the present and direction for the future.

A related aspect of the second stage is the mourning phase, and Herman (1997) described this stage as “the most necessary and the most dreaded task of this stage of recovery” (p. 188). Mourning consists of acknowledgement and recollection of one’s trauma, which often results in feelings of extreme loss and grief. Fantasies of revenge, forgiveness, and compensation are common but not necessary to the survivor’s healing. Herman (1997) stated, “Mourning is the only way to give due honor to loss; there is no adequate compensation” (p. 190).

Reconnection is the final stage of recovery. At this point, the survivor has come to terms with the past trauma. In doing so, the survivors have reconnected with themselves and have moved from positions of helplessness and isolation to empowerment and reconnection. They can now begin to actively reengage with others in their environment, build new relationships, and ultimately, construct new lives. “The survivor no longer feels possessed by her traumatic past; she is in possession of herself” (Herman, 1997, p. 202).

II. Individual Trauma Treatment Models

The concept of trauma-related emotional disturbance dates back over a century; yet, as noted earlier, it was only officially categorized as PTSD less than 15 years ago in the *DSM-III* (Foa & Meadows, 1997). Because PTSD was so recently recognized as a formal disorder, treatments for trauma are varied, and research and evaluation of their effectiveness is ongoing. In this section, various individual, one-on-one, trauma treatment interventions are presented; these include: crisis intervention, hypnotherapy, eye movement desensitization and reprocessing (EMDR), cognitive behavioral therapy (CBT), psychodynamic treatments, pharmacological treatments, and narrative therapy.

Crisis intervention. Foa and Meadows (1997) have asserted that immediate intervention following a traumatic event is crucial despite a lack of research on the efficacy of such interventions. It is believed that the faster debriefers can respond following a traumatic incident, the more the victims can be helped (Watters, 2010).

Many crisis interventions are based on Mitchell and Bray's (1990) seven-phase crisis intervention stress debriefing (CISD) approach. Critical Incident Debriefing (CID) is a cognitive behavioral debriefing treatment that is typically implemented within 72 hours of a traumatic event and is designed to promote the emotional processing of traumatic experiences. The format involves a peer-led and clinician-guided group meeting that often lasts several hours (Mitchell & Bray, 1990).

The seven phases of treatment include: (a) an *introduction* during which the process is introduced and safety and confidentiality are discussed; (b) a *fact phase* whereby group members are encouraged to describe the incident and facts pertinent to the event; (c) a *thought phase* during which the group leader encourages group members to reflect on their initial and subsequent thoughts following the incident; (d) a *reaction phase* whereby group participants begin to move from an intellectual mode of processing to a more emotionally expressive and cathartic one; (e) a *symptom phase* where participants share with one another the cognitive, physical, emotional, and behavioral symptoms of distress that presented within 2 hours of the critical incident; (f) an *education phase* where a mental health professional educates group members about the effects of traumatic stress; and (g) a *reentry phase* which is the final phase during which additional questions are addressed, referrals are made, and group bonding is reinforced as group members discuss ways in which they may support one another in the future.

The American public's awareness of PTSD and respect for trauma counseling grew in 1989 following disasters such as Hurricane Hugo in South Carolina, the Loma Preita earthquake in the San Francisco Bay Area, and Hurricane Andrew in Florida (Watters, 2010). Despite public and professional belief that trauma debriefing was necessary to treat traumatized populations, there was little evidence that such efforts were helpful. In fact, early studies that examined such interventions found crisis interventions were ineffective and even harmful in many situations. It was believed that such treatments were priming distressed individuals to experience certain symptoms by suggesting certain reactions (Watters, 2010). Similarly, many researchers believe trauma victims would receive greater benefit from interventions that do not occur immediately following a traumatic event when an individual is likely to be in a state of shock (Foa & Meadows, 1997). Despite such evidence crisis intervention treatments continue to be used.

Psychosocial treatments for PTSD. Many psychosocial treatments have been developed for dealing with PTSD. These include hypnotherapy, eye movement desensitization and reprocessing (EMDR), cognitive behavioral therapy (CBT), psychodynamic treatments, pharmacological treatments, and narrative therapy.

Hypnotherapy. Hypnosis dates back to the early 19th century and was first used by Freud to treat trauma-related distress. Freud originally introduced the procedure to produce the abreaction and catharsis he believed were necessary to resolve psychic conflict (Foa & Rothbaum, 1998). The theory behind hypnotherapy is that it elicits emotionally charged memories, and then the hypnotherapist controls the individual's somatic response to these. This method facilitates a working-through of the trauma by

allowing the individual access to the affect associated with it (van der Hart & Spiegel, 1993). There are no arguments among researchers that hypnosis has merit in the treatment and alleviation of trauma and trauma symptomatology; however, Foa and Meadows (1997) argued that the studies measuring the efficacy of hypnotherapy are not methodologically sound, and therefore, are not adequate to assess the efficacy of hypnosis for the treatment of PTSD and its associated symptomatology.

In a study by Brom, Kleber, and Defres (1989) that compared hypnosis, desensitization, and psychodynamic psychotherapy, researchers found that although all treatment conditions demonstrated improvement in PTSD-related symptoms, no differences were found between the efficacy of each treatment. These findings suggest that hypnotherapy, desensitization, and psychodynamic therapy may all be equally effective for alleviating trauma symptoms. However, in a more recent meta-analysis, van Etten and Taylor (1998) found cognitive behavioral methods and EMDR (eye movement desensitization and reprocessing) to be superior to other therapies, including hypnotherapy, relaxation, and dynamic psychotherapy. In a more recent review of empirically supported psychological treatments for adult acute stress disorder (ASD) and PTSD, Ponniah and Hollon (2009) found that trauma-focused CBT and EMDR are the psychological treatments of choice for PTSD although they caution that further research of these therapies with different populations is needed. Furthermore, due to limitations of testing within the full range of trauma types, stress inoculation training, hypnotherapy, interpersonal psychotherapy, and psychodynamic psychotherapy can only be considered to be *possibly* efficacious treatments for PTSD (Ponniah & Hollon, 2009).

Eye Movement Desensitization and Reprocessing (EMDR). EMDR, developed in 1987 by Francine Shapiro, is a relatively new but widely used and effective therapy method for the treatment of PTSD (Irnsn, Freund, Strauss, & Williams, 2002; Maxfield & Hyer, 2002; Wilson, Becker, & Tinker, 1995). It integrates elements of psychodynamic, cognitive behavioral, interpersonal, experiential, and physiological therapies in conjunction with bilateral stimulation to address memories related to traumatic events. This therapy technique is based on the premise that distressing memories that have been stored without sufficient processing are transformed when an individual is able to connect these memories with more positive and realistic information, thereby alleviating the distress caused by the disturbing events. Reprocessing therefore leads to cognitive shifts, greater insights, and the gradual adopting of more adaptive behaviors (Shapiro, 1995).

In EMDR, the client is instructed to focus on a disturbing image or memory as well as the emotions associated with it. Once this is achieved, the therapist introduces bilateral stimulation induced by auditory or tactile stimuli or the therapist's movement of their fingers in front of the client's face. The client is instructed to follow the therapist's movements while simultaneously focusing on the disturbing content, thus allowing the individual to access traumatic material and his or her associations to the material in the safety of the present moment (Seidler & Wagner, 2006).

In their review of the literature, Ponniah and Hollon (2009) reported that findings have been mixed regarding the efficacy of EMDR. Several studies have found EMDR to be a superior treatment to trauma-focused cognitive behavioral therapy (CBT) whereas other studies have reported PTSD symptom reduction to be similar when comparing these

two treatment modalities (Ponniah & Hollon, 2009). Silver, Rogers, Knipe, and Colelli (2005) evaluated EMDR's use as an early intervention treatment for collective trauma by studying its utility in the wake of the attacks on the World Trade Center. Their findings indicated that EMDR effectively decreased anxiety, depression, and PTSD symptoms in participants. Based on these findings, these researchers concluded that EMDR is a useful intervention for treating individuals both in the acute phase of trauma reactions as well as those who present with longer-term trauma responses.

Cognitive Behavioral Therapy (CBT). A second form of behavioral intervention is cognitive behavioral treatment (CBT), which is the most widely studied psychosocial treatments for PTSD. Interventions are often time limited, goal oriented, and systematic, and utilize a number of cognitive strategies as well as behavioral techniques. Cognitive interventions aim to challenge and eventually change the irrational and maladaptive cognitions that often accompany psychological distress. Behavior interventions may include assertiveness and relaxation training as well as various exposure techniques to assist with the gradual desensitization of feared objects (Seidler & Wagner, 2006).

Many studies have shown that both EMDR and CBT are effective in the treatment of PTSD (Bradley, Greene, Russ, Dutra & Westen, 2005; Davidson & Parker, 2001; Seidler & Wagner, 2006; van Etten & Taylor, 1998). However, in spite of these numerous studies, these researchers have also raised an important question (previously noted by Schnyder, 2005) regarding whether these exposure techniques might, in fact, retraumatize and increase PTSD symptomatology in more severely disturbed and traumatized individuals. Moreover, Schottenbauer et al. (2008) pointed out that, although CBT and EMDR are empirically supported treatments for PTSD, they are also associated

with high drop-out rates. In addition, some individuals do not respond to these treatment modalities, and in some cases, their symptoms even worsen posttreatment.

Schottenbauer et al. (2008) supported Herman's (1997) hypothesis that PTSD symptomatology differs depending on whether the individual has been exposed to one trauma (simple trauma) or cumulative traumas (complex trauma), and that this distinction is crucial to understanding variations in response to therapeutic interventions. For instance, CBT and EMDR do not address the full range of issues experienced by individuals with significant and extensive trauma histories (Cook, Schnurr, & Foa, 2004); therefore, interventions aimed solely at reducing PTSD symptoms (e.g., CBT and EMDR) may not be adequate for individuals who have experienced prolonged trauma. Schottenbauer et al. (2008) argued further that psychodynamic interventions, discussed next, which focus on interpersonal relationships, may be more effective in engaging individuals with specific personality characteristics who might otherwise be very difficult to treat.

Psychodynamic treatments. Although no manuals exist, and it has been understudied, psychodynamic psychotherapy is widely used in the treatment of PTSD (Schottenbauer et al., 2008). Several studies have demonstrated the efficacy of such therapies (Brom, Kleber, & Defares, 1989; Leichsenring, Rabung, & Leibing, 2004). The focus of psychodynamic psychotherapy is to alleviate psychic tension by bringing unconscious content and conflicts into conscious awareness. Elements of this treatment include a strong focus on intrapersonal and interpersonal themes, as well as an analysis of denial and the defenses these individuals use to keep feelings, wishes, and impulses out of their awareness (Blagys & Hilsenroth, 2000).

McWilliams (2004) emphasized that in a psychodynamic psychotherapy, traumatized individuals learn that they can protect themselves from things they once had no control over and that every situation is not an event that will necessarily cause retraumatization. Trauma survivors often have intense transference reactions to their therapists as they may experience them as similar to those who have hurt them in the past. For this reason, McWilliams (2004) believes it is often difficult for trauma survivors to trust the therapist or believe that they are someone who can hold their best interests in mind. The slow process of learning to differentiate the past from the present is therefore a crucial element in the treatment of these individuals (McWilliams, 2004).

As LeDoux pointed out, psychotherapy strengthens the prefrontal cortex, a part of the brain that helps to protect against the invasion of traumatic memories (LeDoux, 1992, as cited in McWilliams, 2004). Survivors can also learn in treatment how to avoid situations that will stimulate their traumatic memories, and although it is not typical for psychoanalytically oriented therapists to give direct instruction, therapists often advise survivors of trauma in this way. McWilliams stressed that when the therapist takes this stance, the survivor can begin to:

internalize our own conviction that they can protect themselves from retraumatization, that they are not doomed to repeat the past, and that they do not deserve to suffer any more damage beyond the insults of mortality and vulnerability that are inevitably a part of life. (McWilliams, 2004, p. 253)

Pharmacological treatments. Trauma results in the dysregulation of multiple neurochemical systems. Pharmacotherapy has been used to help alleviate symptoms and facilitate recovery in individuals with PTSD for over 100 years. A range of medications has been used in the treatment of PTSD; however, antidepressants, specifically selective serotonin reuptake inhibitors (SSRIs), are the most frequently studied and prescribed

medications for PTSD (Keane et al., 2006). One such study was conducted by Albucher and Liberzon (2002). In their review of psychopharmacological treatments, they found antidepressants to be the most efficacious treatment for PTSD, especially in patients who experienced depression, sleep disturbance, or intrusive and hyperarousal symptoms.

Anticonvulsants are typically used in conjunction with antidepressants to treat patients with impulse control problems, irritability, and aggression (Albucher & Liberzon, 2002). They have also been used to treat PTSD-related symptoms; however, the literature on their effectiveness is sparse. Some case studies have concluded that they may be effective in treating PTSD (Friedman, Davidson, Mellman & Southwick, 2000), but these medications often carry with them a number of significant side effects, which make them less efficacious.

The third drug type, antiadrenergic agents, has been shown to be effective in the treatment of some symptoms of PTSD. This drug has been shown to reduce nightmares, improve sleep, and reduce other PTSD-related symptoms (Raskind, Peskind, Kanter, Petrie, Radant, Thompson et al., 2003). A study by Pitman, Sander, Zusman, Healy, Cheema, Lasko et al. (2002) demonstrated that antiadrenergic medications may be effective in preventing PTSD symptoms when administered immediately following a traumatic event. These findings point to the importance of continuing the study of antiadrenergic agents in the treatment and possible prevention of PTSD.

Finally, recent studies have shown atypical antipsychotics to be effective in reducing PTSD-related symptoms (Ahern, Krohn, Connor, & Davidson, 2003). These medications may be particularly useful in treating psychotic symptoms, extreme hypervigilance or paranoia, dissociation, or intense anger (Keane et al., 2006).

The extent to which medications and pharmacotherapy can be used to treat PTSD is still largely unknown. Clearly, a better understanding of the psychophysiology of PTSD and the effects of early trauma is essential for the development of more specific pharmacological agents, as well as the expansion of early intervention and prevention strategies for PTSD.

Narrative therapy. Narrative therapy was initially developed by Michael White and David Epston in their seminal book, *Narrative Means to Therapeutic Ends*. It is a respectful, nonblaming approach to treatment that asserts that identity is largely shaped by the stories and narratives people construct about their lives. The goal of narrative therapy is to focus on the effects that narratives have on people's lives rather than focusing on the problems that people carry around inside. In so doing, individuals are able to distance themselves from their problems, seeing them as separate from their own identities through a process of externalization (Morgan, 2000). White and Epston (1990) asserted that once a person is able to see a problem as separate from his or her identity, an opportunity for change has been created, and the individual can begin to re-author his or her story from a more positive perspective. Through the process of putting an experience into words, one can begin to regain the capacity to imagine alternative outcomes. In this way, the influence of the problem is reduced, and new possibilities are created through the development of more adaptive narratives (Morgan, 2000).

Narratives formed during and in the aftermath of trauma are frequently incomplete, and this partial picture of the event may in itself contribute to the posttraumatic stress. Survivors of a trauma may have difficulty recalling details related to the event, and as such, their story can be disorganized with many gaps (Tuval-

Mashiach, Freedman, Bargai, Boker, Hadar, & Shalev, 2004). This then contributes to the inability to process trauma-related information, which may be a factor underlying PTSD, and it may also lead to more chronic trauma-related disturbances (Amir, Stafford, Freshman, & Foa, 1998; Joseph, Williams, & Yule, 1995).

A principle task, then, in working with traumatized populations is to assist people in constructing stories or narratives that help to contain and organize their traumatic experiences, which will then help them to better cope with their suffering (Graybill, 1999; Wigren, 1994). Tuval-Mashiach et al. (2004) believed that sharing one's trauma experience or story with another helps the survivor to construct a detailed, coherent, and chronologically accurate trauma story. Once the construction of the narrative is complete, the survivor begins to make meaning and regain control over his or her trauma and can then start incorporating it into the larger autobiographical story.

III. Collective Trauma Treatment Models

Herman (1997) emphasized the importance of groups in healing trauma and addressing the social relational issues that often result from traumatic experiences. "The solidarity of a group provides the strongest protection against terror and despair, and the strongest antidote to traumatic experience" (Herman, 1997, p. 214). The group environment offers members the solace of being in the presence of supportive others who have been through similar experiences and serves to metaphorically welcome victims of trauma back into the world of humanity. With a particular focus on strengths, group members are encouraged to draw upon the resources and strengths of other group members and in doing so, the group as a whole, begins the process of grieving past losses, integrating traumatic experiences, and refocusing their lives in the present.

There are several reasons why collective treatment methodologies are preferable to one-on-one trauma treatment models. In nonwestern, nonwhite communities, communal treatment is often much more common and part of the culture. Whereas western culture emphasizes individuality, nonwestern family and tribal-based cultures often view physical or mental dysfunction or disease as community-wide cultural issues and not problems that are unique to the individual (Diller, 2011; Levine, 1997). Treatment and healing in these communities therefore requires the active involvement of all tribal members within a communal setting. Collective treatment methods encourage the individual to merge their identity with other members in the group to form a collective whole, and this process can strongly influence the generation of new behaviors (Diller, 2011).

A broader cultural view of trauma treatment also allows for the use of a wider range of techniques and interventions such as expressive arts, rituals and rites of passage, and celebration to bond communities and individuals and facilitate healing (Diller, 2011; Levine, 1997). Since traumatization is so widespread, collective treatment models, especially those that are intensive and short-term, can provide treatment to more individuals and facilitate healing through multiple witnessing in a way that one-on-one individual treatment models cannot (Diller, 2011).

Narrative documentation. Trauma can also be collectively shared within a community or among a group of people (Denborough, 2008). When a community is subjected to trauma, individuals within the community share the common experience of feeling isolated from others. One means for addressing this experience of alienation, isolation, and the larger effects of the trauma is to prepare a collective narrative document

(Denborough, 2008). Such a document “weaves together the skills and knowledge of a number of people who are dealing with certain hardships or difficulties” (Denborough, 2008, p. 32). This methodology can take the form of poems, lists, certificates, or therapeutic letters (White & Epston, 1990). Once the document has been completed, a ceremonial retelling (White, 1999, as cited in Denborough, 2008) can help the traumatized community, thereby creating a sense of “communitas,” or shared unity, among those individuals who have gone through similar processes (Turner, 1969). This process also allows for the development of what White (2004) described as “full memories” of trauma whereby communities can collaboratively remember responses to a traumatic experience rather than disparate and individual stories about the traumatic events and its resulting effects. Moreover, through narrative documentation, a culture’s healing practices can be remembered, restored, and strengthened.

Another important element in collective trauma treatment is the role of witnessing. “Outsider witnesses” can interview individuals and families, listen to experiences and issues and then provide feedback (White, 1999, as cited in Denborough, 2008). These outsider witnesses may be professionals, family, friends, or other people who have experienced similar traumas or difficulties (Denborough, 2008). The outsider witness’s role is to bear witness and acknowledge the storyteller, and in doing so, allow the storyteller to impact the lives of the witnesses (Denborough, 2008).

Tree of life approach. The Tree of Life methodology was initially developed by Ncazelo Ncube and David Denborough in 2005 for use with children in South Africa who were living in abusive or violent situations and who had experienced loss due to the effects of neglect or HIV/AIDS (Denborough, 2008). The methodology sought to assist

these children in speaking about their lives and traumatic experiences in a way that was not overwhelming. Since its development, the Tree of Life approach has also been found to be helpful in working with adults as well as adapted for use in working with children in a variety of cultural contexts (Denborough, 2008). This approach consists of a four-part group process whereby each child is encouraged to construct a “second story” of his or her life by drawing a “Tree of Life,” designating different parts of the tree to symbolize various aspects of the child’s life, family, community, hopes, dreams, and wishes for the future (Denborough, 2008). In addition, the children are encouraged to record their skills and strengths on parts of the tree.

In the second phase of the Tree of Life approach, the children identify the various hardships they have faced and illustrate the ways they have coped with these difficulties. They then share the stories of their tree with the group (Denborough, 2008). Following the creation and discussion of their trees, a space is created in the third phase for the children to speak about or name current challenges they are experiencing. These challenges and the resulting effects the trauma has had on their lives are then acknowledged by the group. Special attention is paid to the strengths that the children have demonstrated during their hardship, while at the same time, ensuring that this Tree of Life experience will not retraumatize them (Denborough, 2008). Facilitators encourage discourse about the ways the children can respond to their challenges and the people that they can seek out for support and assistance. Children are also educated about various protective behaviors that will help keep them safe from future risk of harm.

In the final phase, children are presented with specially made individual certificates that pertain to their hopes, dreams, and skills. Songs are sung and outsiders

are invited to attend this certificate-giving ceremony, which offers another chance for witnessing each child's traumatic experiences.

In summary, the Tree of Life methodology is a collective narrative methodology that responds to the experience of vulnerable children. Children are provided the opportunity to re-author different relationships in their lives and share in collective conversations that provide them with the opportunity to get to know each other in a different context. Lastly, older generations have the opportunity to serve as witness to the child's experience, honor and acknowledge their skills, take pride in the child's unique contributions to the community, and identify ways in which the child can carry on the positive legacy of their forebears (Denborough, 2008). On an even deeper level, this methodology can help strengthen vulnerable children while also drawing upon the children's personal and collective knowledge to forge positive action for social change (Denborough, 2008).

Just therapy. Just Therapy is a straightforward and reflective narrative-based treatment approach that can address complex problems that have frequently been referred to as 'social' therapy. It emphasizes spirituality, justice, and simplicity in treatment while taking into consideration the gender, cultural, social, and economic context of people seeking help (Waldegrave, Tamasese, Tuhaka, & Campbell, 2003). In essence, Just Therapy strives to help individuals or families move from problem-centered stories of pain to stories of resolution and hope through the encouragement and creation of new meanings and stories. Its methods enable a broader range of people to serve as therapists, especially communal leaders and others with extensive cultural experience and knowledge (Waldegrave, Tamasese, Tuhaka, & Campbell, 2003).

The Just Therapy methodology emerged from the recognition that families seeking help at The Family Centre in New Zealand struggled from problems that were enforced by broader social structures like poverty, patriarchy, and racism. The staff in the agency realized that therapy was addressing people's symptomatic behavior as if it were a family problem and then returning these individuals back into the same context that had initially created their problems. The agency addressed this problem by adopting a practice modality that was centered on the cultural identity of those they were treating as well as a community development approach to their work with these populations.

Therapy focuses on the story created and articulated during a conversation between family members. While the family is telling their story, the therapist takes a respectful and concerned stance, listening carefully to the meaning attributed to events that have become problematic. The therapist honors the family's story by respecting its significance for the people involved. Unlike traditional Western approaches to treatment, the therapist remains relatively inactive during this process, avoiding advising, interpreting, or interfering with the story in any way. The principle task of the therapist is to draw out and understand the story, using clarification questions when necessary. When the story is felt to be complete, the therapist leaves the family members to reflect either amongst themselves or with a colleague that has been observing the process through a reflective glass.

The therapist then analyzes the problem-centered story and prepares a message, also known as a reframe or intervention. Central to this message is the fact that the language used by the therapist is colloquial and designed to echo the phrases used by those telling the story. This serves to provide a link between old and new concepts. The

offering of an alternative meaning helps to deconstruct rigid problem-centered patterns. Following the delivery of the message, the interview is concluded without further discussion. The idea is that the alternative, reauthored story has had an impact on the problem-centered meanings that people make of their experience, promoting feelings of liberation and self-determination (Waldegrave, Tamasese, Tuhaka, & Campbell, 2003). Client families are thus encouraged to begin a process of viewing their lives and relationships differently.

IV. Healing of Memories (HOM) Workshop

Historical origins of the workshop. When countries transition to democracy, they are often faced with the issue of how to achieve peaceful coexistence between different groups in a society who have a long history of conflict with one another. Truth commissions are “bodies set up to investigate a past history of violations of human rights in a particular country—which can include violations by the military or other government forces as well as armed opposition forces” (Hayner, 1994). Truth commissions work toward bringing about social transformation and emphasize healing through restorative justice by providing a platform for perpetrators to give testimony and for victims to speak about what happened to them. Hayner (1994) emphasized that truth commissions are officially sanctioned and authorized by the State. They aim to establish what happened in the past by investigating a pattern of abuse and human rights violations that occurred over a set period of time. At the end of all proceedings, the commission produces a public report that summarizes key findings and makes recommendations for rebuilding society. In essence, the final report serves to create a framework for a nation to deal with its past (Minow, 1998). Historically, a major question faced by truth commissions operating in

various national contexts has been whether or not to grant amnesty to perpetrators in order to promote reconciliation. Early truth commissions had little public testimony due to fears of retribution. The South African TRC was the first major departure from this trend as it was decided that amnesty would be available, but only to those who applied for it and agreed to fully disclose facts related to their misdeeds (Minow, 1998).

Truth and Reconciliation Commissions in South Africa. Between 1948 and 1994 in South Africa, a system of legal racial segregation, called Apartheid, was instituted and enforced by the National Party government, which curtailed the rights of black, colored, and ethnic populations. This government mandate sparked tremendous internal resistance, resulting in massacres, torture, lengthy imprisonment, and severe social and economic discrimination against large numbers of the population. Finally, in 1995, in an attempt to address the country's horrific past, the Truth and Reconciliation Commission (TRC) was established by the South African government following the abolition of apartheid.

The goal of the TRC was to bring healing and national reconciliation, rather than retribution, to the people of South Africa by inviting victims of gross human rights violations to give statements about their experiences in a public hearing forum (Stateman, 2000; Tutu, 1999). In addition, perpetrators of apartheid violence were permitted to give testimony in exchange for amnesty from civil and criminal prosecution. This process was unique in that it emphasized uncovering the truth about human rights violations through gathering evidence and information rather than focusing on persecuting individuals for their crimes. According to Minow (1998), this concept of restorative justice emphasized the importance of "building connections and enhancing communication between

perpetrators, by-standers, and those who were victimized, and forging ties across the community” (as cited in Diller, 2011).

Psychological impact of the TRC. Gillian Straker (1999), a South African psychoanalyst, examined the psychological impact of the TRC on individuals, bystanders, and perpetrators. She identified several important outcomes of the TRC process. First, she found that many of the victims described giving testimonies, or telling their story, as an “amazingly liberating” and therapeutic experience. Straker believed that this process of breaking the silence—or allowing the unspoken to be spoken— was highly validating in that it affirmed the reality of the victims’ experience and thereby liberated them from the grip that their secret had held on them (Straker, p. 257). Additionally, publicly telling one’s story allowed the victim to play an active role in a society’s healing by reconstructing the past and creating a shared narrative. Finally, because trauma ultimately disconnects people from each other and their communities, the TRC functioned to reconnect individuals to their social and geographic communities as well as to greater humanity (Diller, 2011).

Many white South Africans had been bystanders who though not directly involved as perpetrators of crimes, had nonetheless remained silent and therefore benefited from the apartheid regime (Diller, 2011). Throughout the TRC process, many white South Africans were surprised and became emotional after hearing victims’ testimonies, learning for the first time of the atrocities that had been perpetrated against them. Straker (1999) noted how, despite these reactions, these bystanders had remained largely silent and unaware of their role in perpetuating these abuses. It appeared that they were in denial of the events that had occurred during the Nationalist regime. Diller

(2011) asserted that such behavior could be explained by processes of *dissociation* and *splitting* whereby bystanders “project their own unwanted, negative identifications onto out-group members and thereby justify their negative treatment of them” (p.188). He further contended that through this process, empathy and concern became psychologically blocked in the bystander.

It is difficult to accurately determine the impact of the TRC on perpetrators due to uncertainty about whether perpetrators were motivated to give testimony in order to receive amnesty or whether they were motivated by a genuine interest in seeking forgiveness. Gobodo-Madikizela (2010) emphasized that one important outcome of giving testimony for the perpetrator was that they could feel remorse and became rehumanized as they began to see the victim as a human other rather than a dehumanized object. Although perpetrators cannot undo what was already done, “his or her acknowledgement, contrition, and recognition of the victim’s pain can go a long way in contributing to the victim’s journey toward mastery of the traumatic memory” (Gobodo-Madikizela, 2010, p. 24). Forgiveness afforded the perpetrator an opportunity to change, and their testimony provided victim family members details of events, which would allow them an opportunity to form complete narratives and thus begin the healing process (Diller, 2011).

The TRC was also criticized for certain negative psychological impact on participants. Straker (1999), for example, contended that it did not provide space for participants to process complex emotions that surfaced during the truth-telling process. Skinner (2000) in his evaluation of the TRC hearings noted that many participants had found the experience of telling their stories to be retraumatizing, and believed that not

enough services were available to help them cope with the significant anxiety, depression, and anger that were often experienced during the testimonial process (Hayes, 1998; Skinner, 2000). In fact, many participants found themselves ill prepared to return to the pressures and demands of their daily lives (Straker, 1999).

Despite its shortcomings, the TRC represents a serious effort to put into motion processes of individual and collective healing. The Healing of Memories (HOM) Workshop was created as a parallel process to continue the initial efforts of the TRC to address complex social trauma. Since only a relatively small number of South Africans had had the opportunity to give testimony during the hearing process, the HOM provided a process whereby many more South Africans who had also suffered under apartheid could avail themselves of an opportunity to heal. In essence, the HOM helped to facilitate the continuation of the reconciliation process on a much broader level.

Believing that within the context of a safe space, victims could begin to address and process their own complex traumas within the context of their country's past, Father Michael Lapsley developed a collective healing process whereby South Africans would be afforded such an opportunity. To this end Father Lapsley established the Institute for the Healing of Memories (IHOM) in 1998.

Father Lapsley was an anti-Apartheid activist who had experienced apartheid violence firsthand. While living in exile in 1990, Father Lapsley was sent a letter bomb by the apartheid government that resulted in the loss of both of his hands and also compromised his vision and hearing. Through his work at the Trauma Centre for Victims of Violence in Cape Town as well as his own personal process of healing and recuperation, Father Lapsley recognized the importance of providing people with a space

to voice their experiences and have these experiences acknowledged and witnessed by others. He further believed that the healing process was a journey through which an individual was able to move from being a victim and survivor to “a victor over evil, hatred, and death” (as cited in Diller, 2011, p. 189). Whether individually or at a national level, Father Lapsley believed that trauma survivors, if not allowed to participate in such a process of healing would themselves eventually become victimizers. The Institute for the Healing of Memories currently offers workshops for victims and perpetrators of interpersonal or social trauma throughout the world. The HOM methodology has also been successfully applied in helping people cope with a variety of traumas, including gender violence, AIDS, ethnic conflict, and the violence of poverty itself (IHOM, 2007).

The Healing of Memories (HOM) workshop model. The theory of HOM workshops is perhaps best described on their Web site:

Through an exploration of their personal histories, participants find emotional release and as a group gain insight into and empathy for the experience of others. These processes prepare the ground for forgiveness and reconciliation between people of diverse backgrounds, races, cultures, and religions. (Institute for Healing of Memories, 2010a)

HOM workshops are designed to bring together enemies, bystanders, victims, and perpetrators from diverse backgrounds. It is based on the premise that emotional healing is fostered through the process and experience of mutual sharing, which allows individuals to release painful past experiences:

Emotional scars are often carried for very long, hindering the individual’s emotional, psychological, and spiritual development.... The power of the workshops lies in their experiential, interactive nature, and their emphasis on the emotional and spiritual, rather than intellectual, understanding and interpretation of the past. Through an exploration of their personal histories, participants find emotional release and as a group gain insight into and empathy for the experiences of others. These processes prepare the ground for forgiveness and

reconciliation between people of diverse backgrounds, races, cultures and religions. (Institute of Healings of Memories, 2010b)

Group process. At the core of the HOM workshops, participants are assisted—within the supportive and trusting environment of the group—to share their personal stories in a narrative format. The participants are encouraged to explore the feelings evoked by intense memories rather than intellectualize and analyze them.

Reflection is modeled and promoted by facilitators in both large and small group exercises. Reflective functioning, sometimes referred to as mentalization, is a therapeutic technique that draws upon an individual's capacity to imagine the thoughts and feelings of themselves and others, as well as how these thoughts and feelings impact their own behavior (Fonagy & Target, 1997; Fosha, 2001). It is through this process that people are able to make sense of their world.

Within the HOM workshop this technique allows each participant to deepen his or her own experience by having access to a full range of emotions (e.g., anger, hatred, shame, love, joy, and hope). An emphasis is then placed upon releasing or working through unresolved negative emotions collectively. As Father Lapsley believed:

It is about recognising that people often need the space to be able to deal with their deepest feelings, to give themselves into the movement and to begin to let a whole lot of stuff go. A workshop can create that kind of space for people to stand up and see themselves in relation to others—because people are extremely lonely in their deepest feelings. And [at a workshop] they begin to realise other people, often very different people, have traveled very similar kind of journeys. (as cited in Kayser, 2000, p. 14)

Through this process of acknowledgement and bearing witness, participants begin to develop the capacity for empathy and forgiveness, not only for themselves, but also for other members' unique experiences. Herein begins each individual's process, or "journey," toward emotional healing and transformation.

Expressive arts and rituals. It has been widely shown that the process of dissociation and numbing is closely linked to the experience of trauma, and directly following trauma, these states help people cope with their traumatic experiences. However, aspects of the self that become dissociated ultimately prevent the individual from mourning or experiencing life fully (Richman, 2006).

As noted earlier, silence also often associated with trauma, and in fact a common reaction to traumatic events is the inability to talk about what has happened, sometimes referred to as “speechless terror” (Van der Kolk, et al., 1996). For those who have not yet found ways to verbally express their feelings and emotions associated with the traumatic event, these affects are often stored somatically.

Both spiritual rituals and coping strategies, as well as expressive arts, have been found to be effective in restoring traumatized individuals to wholeness. Various studies have shown that traumatized individuals who utilize religious and spiritual coping strategies demonstrate greater physical and emotional health (Ano & Vasconcelles, 2005; Gall, Chabonneau, Clarke, Grant, Joseph, & Shouldice, 2005; Miller & Kelley, 2005; Pargament, 2007). Autobiographical material has also proven helpful in this regard. Richman (2006), herself a child survivor of the Holocaust examined her own personal experiences to demonstrate ways in which autobiographical narratives can facilitate the healing process for individuals who have undergone trauma. She pointed out that creative activities can assist in self-expression and help individuals recover that which has been lost:

Through creative expression trauma survivors have the opportunity to turn something that was once passively endured into something that can be controlled. What was originally overwhelming can be faced by survivors in their own terms and at their own pace. What felt fragmented and meaningless can now be seen in

a context. What was once a source of shame can now be a source of pride, as it is transformed into a beautiful painting, a haunting melody, or an inspired memoir. By sharing the creation with the world, there is an opportunity to come out of hiding, to find witnesses to what had been suffered alone, and then begin to overcome the sense of alienation and isolation that are the legacy of trauma survivors. (Richman, 2006, p. 644)

In a HOM workshop, experiential interventions—in the form of dance, drawing, chanting, singing, ritual burning of negative feelings, and clay peace symbols—provide mediums through which individuals can begin to work through traumatic events by reintegrating aspects of the self and working toward the development of a coherent narrative. In the final celebration phase of the workshop, participants collaborate with each other within small groups, and together put on a performance that is shared in the larger group. Although there may be individually performed parts, the overall performance is a group effort. Through such a structure, participants move from internal reflection and self-processing to membership in a larger group process where they are encouraged to interact and share their experiences and feelings with other participants. Following participants' experience in the HOM workshop, facilitators provide referrals to outside agencies or treatment providers if appropriate.

Storytelling and the importance of narrative. As previously noted, many trauma theorists and researchers on PTSD have emphasized the role of a narrative, or telling one's story, in beginning the process of healing from trauma. Openly speaking one's trauma allows the victim to begin processing the traumatic experience. This process in turn helps to restore continuity and ultimately assists victims in beginning to make sense of their lives. Nachmani (2005) went so far as to suggest that telling one's story is proof of life. Cienfuegos and Monelli (1983) asserted that testimony is a form of catharsis that

“acts by restoring affective ties, by orienting aggression in a constructive manner, and by integrating fragmented experiences.... The process of emotional deterioration is halted and the possibilities for growth are reopened” (p. 50). Telling one’s story, therefore, becomes a therapeutic process whereby victims are able to begin integrating their traumatic experiences within not only the context of their own personal history but also within the larger sociopolitical context (Cienfuegos & Monelli, 1983).

Within the safety of the small group, participants in the HOM workshops use drawing as a starting point to begin to tell their story, and in so doing begin to shift from nonverbal to verbal activity. Participants are given approximately one hour to verbally present their story in whatever ways they choose, and are free to decide what and how much to reveal or disclose to the group. Confidentiality and respect are emphasized. There are very few rules other than that the witnesses must listen compassionately and supportively while the storyteller is speaking. Trained facilitators may, on occasion, take on an “inquisitive stance” and ask questions of the storyteller in order to assess their readiness to progress into deeper, more emotional territory.

The facilitator may also use other techniques commonly found in narrative and group therapy interventions, including pointing out aspects of the here-and-now interaction and restating facts in the participant’s story. By assisting participants in deepening their affective and emotional experience, the facilitator helps promote healing. Through their storytelling, the participants begin to more clearly understand and make sense of their traumatic experiences. Offering one’s story in a supportive and controlled group context, empathy is promoted both in the storyteller as well as in the witnesses as both broaden their perspective of the hurtful act, thus shifting from a more rigid position

to one that is more expansive. Empathy then promotes forgiveness and reconciliation while, at the same time, reconnecting and enhancing relationships with one's self as well as with others.

It is important to recognize that forgiveness does not mean excusing, condoning, forgetting, or accepting the behavior or action as a perpetrator. Rather:

It points to a process of healing within the victim, whereby he or she is able to disconnect from destructive defenses and reactions, such as anger and guilt, brought to bear intrapsychically in reaction to a traumatic experience and which keeps the person locked within its parameters. (Diller, 2011, p. 190)

By acknowledging the unresolved traumatic memory and sharing one's lived experience with trusted witnesses, a new beginning and opportunity for growth as been created. In so doing, the victim is thus able to begin letting go of grievances from the past and can begin to focus on directions for the future (Gobodo-Madikizela, 2003).

In summary, HOM workshops emphasize emotional rather than intellectual understanding of one's past experiences. Within this experiential and interactive model, participants can begin to explore and gain insight into some of the more negative feelings surrounding their experiences of suffering, which ultimately promotes healing on the individual level. Collective healing is fostered through the development of empathy for others and the empowerment that results from having one's traumatic experience witnessed by others. This process ultimately promotes forgiveness, reconciliation, and healing.

Previous HOM studies. Very few empirical studies have focused on the impact of HOM workshops on participants and whether the effects of participating in a workshop are sustained over time. Three relevant studies were identified.

The first study, conducted by anthropologist Undine Kayser (2000) examined the HOM process and its use as an intervention tool in addressing healing and reconciliation. Specifically, Kayser looked at the long-term impact of key variables believed to be operative in the workshop's format: *forgiveness*, *reconciliation*, *ubuntu* (humanity to others), and *anger*. Based on participant observation and 10 qualitative interviews, Kayser (2000) constructed possible impacts of the HOM workshops. The important themes that surfaced included: opening up, telling one's story and listening to one another, rediscovering a common humanity, meeting across physical boundaries, bridging separate realities, experiencing a sense of belonging, healing, getting the "poison out," expressing both anger and forgiveness, exploring the role of religion and spirituality. She also considered the differential impact of a single session encounter verses long-term engagement. Kayser's study was the first to undertake an empirical uncovering of the HOM process to identify to better its impact on participant experiences, thoughts, emotions, and beliefs. Kayser recognized the potential such workshops could have in a "once-off weekend experience" and encouraged further exploration into the effects of such initiatives.

A second study of the impact of HOM workshops was undertaken by Nathan (2009). In her dissertation, she investigated the effects and interaction between forgiveness and empathy in relation to collective trauma treatment. Specifically, Nathan examined the impact of a HOM workshop on changes in forgiveness and empathy for 17 group participants. Her research tested two related hypotheses: whether participation in a HOM workshop could enhance one's capacity to forgive and whether such participation could also enhance one's capacity for empathy. The participants in Nathan's study

demonstrated significant increases in levels of forgiveness in immediate post-workshop measures as compared to pre-workshop measurements. Similar significant results were obtained when a 2-month follow-up measure was compared with the pre-workshop measure, suggesting a sustained effect over time. Nathan's research also demonstrated a decrease in pathological symptoms in both the post- and 2-month follow-up measures. These findings suggest possible improvement in one's sense of self and beliefs about others as well as a decrease in possible pathological symptoms related to trauma. Finally, Nathan found significant increases in levels of reported empathy in participants following reflection on their experience of listening to another participant's story. Overall, Nathan's results demonstrated the efficacy of the HOM workshop model as a treatment modality in relation to forgiveness, empathy, and trauma recovery.

In a third study Niyodusenga and Karakashian (2009) conducted a formal program evaluation of a series of HOM workshops conducted over time in South Africa. Through the use of questionnaires and in-depth interviews, these researchers analyzed narratives from workshop participants and workshop facilitators to identify and examine common themes in the participants' experiences. More specifically, the researchers were interested in the following questions: how participants experienced the workshop, the extent to which participants were able to let go of painful feelings from the past, what changes in the perception of other participants took place, and whether the effects of the workshop endured over time.

Niyodusenga and Karakashian's (2009) findings supported the workshop's basic assumptions: that is, having one's pain acknowledged is a healing experience that fosters empathy for the experience of others and reduces feelings of isolation. The researchers

found that the effects of the workshop were still present at the 2-month follow-up interview. Overall, participants reported that the workshops were positive, life-affirming experiences that both empowered them and in various degrees freed them from painful pasts. Participants further felt that one workshop was not adequate and that additional workshops would likely be beneficial. Niuodusenga and Karakashian offered a caveat: some more fragile participants may not be prepared for the emotional intensity of the workshop, and that it is possible that these individuals' experience varying degrees of retraumatization during the workshop.

Summary of Literature Review

Humans have been experiencing trauma for thousands of years and most people will have experienced a traumatic event at some point over the course of their lives (Levine, 1997). Individuals and societies that have been exposed to trauma are often left alone in silence to cope with the unprocessed and fragmented memories surrounding the trauma. This leaves victims feeling helpless, vulnerable to retraumatization, and at risk for a variety of mental as well as physical health issues. In addition to the cumulative effects of trauma experience, symptoms if untreated, can be passed down inter-generationally, i.e., transmitted to the subsequent generations.

There are many ways to define trauma and a variety of different treatment approaches have been developed to address trauma symptoms. Herman (1997) developed a three-stage model of recovery for the treatment of trauma. She emphasized the importance of a group treatment to help facilitate healing through the process of mutual witnessing, forgiveness, and reconciliation. Within the safety of the group

environment, victims can begin to move forward from the fear and disconnection associated with the past to imagine new possibilities and directions for the future.

The HOM is a collective, narrative-based trauma treatment model that has been designed to facilitate healing in individuals suffering from both individual and social trauma experiences. Little, however, is known about treatment methodologies that can facilitate healing in those who suffer from either subclinical or transgenerational trauma symptoms. This author believes that the HOM may serve as an effective model for the treatment of individuals and groups that do not meet the criteria for PTSD, but nonetheless continue to be impacted by traumatic experience. The following study will examine the experience of individuals following participation in an intensive HOM workshop and determine what aspects of the HOM process they find healing and impactful. It is believed that these findings will provide support for the efficacy of the HOM as a narrative-based collective intervention that helps facilitate healing in populations with subclinical trauma symptomatology.

Chapter III: Method

This study explored participants' experience of an intensive 2-day HOM workshop, utilizing qualitative research methods. This chapter includes the following sections: the research question, a description of the participants and how they will be recruited, the procedures that will be used in the collection of data, and the method that will be used for data analysis.

Research Question

In assessing the impact of the trauma treatment method, HOM workshop, the current study employs a qualitative content analysis of interviews from participants about their experience of an HOM workshop. Repetitive patterns of experience are identified across subjects in order to evaluate the HOM as a collective trauma treatment for subclinically traumatized populations and determine which aspects of the workshop participants find central to their healing process.

Participants

Study participants were 11 individuals who participated in a 2-day HOM workshop at a graduate school in Berkeley, California, which took place April 30 to May 2, 2010. The majority of participants were graduate students enrolled in a full-time psychology doctorate program.

Recruitment. Participants were recruited via an e-mail letter of invitation (Appendix A) sent by both this researcher and the dissertation chair, Dr. Jerry Diller. Potential participants were informed of the general nature of the research being conducted and were given primary information regarding the total time investment required for participation.

Procedure

Individual face-to-face interviews were scheduled with workshop participants who expressed an interest and willingness to participate in this research study. Ten interviews took place in a private room located on participants' school campus and one interview was conducted in a private home. At the beginning of each interview, participants were provided with a verbal and written description of the study (Appendix B). Informed consent and the protocol to maintain confidentiality were reviewed and discussed with each participant prior to their signing the required form (Appendix C). In addition, participants were asked permission to audio record the interview, and signed a Consent to Tape Record form (Appendix D). Participants were given the option of keeping the Letter of Introduction (Appendix A) in the event that they had any kind of negative response to the interview process or wished to contact this researcher regarding other issues, questions, or concerns.

Study participants were offered a \$25.00 gift card as compensation for their participation, which they received at the beginning of the interview process. Participants were informed that they need not return this gift card should they elect to discontinue or not complete the interview process.

Interviews ranged in length from 30 minutes to 1 hour. Approximately 10 minutes were allotted prior to beginning each interview in order to build rapport and create a comfortable environment so that the participant would feel at ease discussing and disclosing various aspects of his or her experience. All interviews were audio recorded, and the interviewer followed a semistructured format using a questionnaire (Appendix E). Participants were informed that the interview consisted of a series of questions, both

general and more specific. Participants were informed that the interviewer was generally interested in the unique experience of each participant, and were therefore encouraged to speak freely and openly about their experience. The interviewer varied the order of the questions, omitted questions, and added clarifying questions in order to maintain a sense of flow and allow all participants to tell their narrative in their own way. Participants were informed that they could decline to answer any questions or terminate the interview at any time.

At the end of the interview, participants were offered the opportunity to receive a brief summary of the results at the completion of the study and were invited to follow up with the interviewer via e-mail. In addition, time was allotted at the end of each interview for participants to ask questions regarding the workshop, the study, the interviewer, or the research method. Participants were given information regarding how to contact the researcher should they wish to receive additional information about the study or have future questions or concerns regarding their participation or the results.

Although no discomfort was expected to result from the interview process, the interviewer inquired about the experience of participating in the research study at the close of the interview. No negative responses were expected to be reported. Copies of the study description and informed consent documents (Appendices B and C) were submitted to The Wright Institute Committee for the Protection of Human Subjects (CPHS) prior to the recruitment of participants.

All interviews were transcribed. Printed transcripts were then coded into categories and separate documents for each category were created using a color-coding system. Each category was further divided into major categories and minor categories.

The coding structure can be found in Appendix F. Once completed, all data was analyzed for themes.

Protection of Participants

The risks related to this study were minimal and no deception was used. Although confidentiality could not be guaranteed, it was protected to the full extent of the law. Signed consent forms and participants' contact information was stored in a locked location and kept separately from the research data. All participants were assigned pseudonyms and a number ensuring that participants' names were not connected to their responses. All transcribed and recorded materials were stored on a password-protected flash drive and secured in a locked file cabinet behind a locked door. The researcher will retain the passwords and lock combinations for the raw data and is the only person with access to this information.

Upon completion of the study, all audio recordings will be erased and forms containing the identifying information of participants will be destroyed. Identifying information will be removed from the transcripts, and this data will be retained on a password-protected flash drive in a locked file cabinet in the event that it is needed for future research or teaching purposes.

Data Analysis

A qualitative research method termed content analysis was utilized in this study.

Neuendorf proposed:

Content analysis is a summarizing, quantitative analysis of messages that relies on the scientific method (including attention to objectivity-intersubjectivity, a priori design, reliability, validity, generalizability, replicability, and hypothesis testing) and is not limited as to the types of variables that may be measured or the context in which the messages are created or presented. (Neuendorf, 2002, p. 10)

Although the content analysis technique was used as early as the 17th century, contemporary content analysis was developed in 1931 by Alfred Lindesmith and a small group of researchers at Columbia University (Content Analysis, 2011). According to de Sola Pool, content analysis gained popularity in the 1950s and 1960s and began to spread to other disciplines. At that time, the focus shifted to concepts rather than words, and on semantic relationships rather than presence (Content Analysis, 2011). In order to lend credibility to the method of content analysis, subsequent paragraphs will provide a comparison of content analysis to the grounded theory approach.

Grounded theory, originally developed by Glasser and Strauss (1967) as an adaptation to content analysis, was later revised by Strauss and Corbin (1998). It is the most common and well-known approach used in the analysis of narrative data. Grounded theory methodology is very similar to that of content analysis; however, the two methodologies differ in several significant ways. Suddaby (2006) argued, “The important difference is that grounded theory describes an overall method for systematically gathering and analyzing data, but content analysis describes a specific context within which a distinct type of data can be gathered and analyzed” (p. 636). In addition, grounded theory aims to develop a theory (Glasser & Strauss, 1967) and utilizes a technique known as constant comparative analysis, which refers to the simultaneous collection and analysis of data throughout the data collection process.

This study was primarily interested in examining the experience of participating in a Healing of Memories workshop and not in the development of a new theory. Furthermore, content analysis allows for an analysis of data at the manifest level, as well as at the latent level, allowing the researcher the flexibility to more deeply analyze and

interpret the underlying meaning of the text. Given these reasons—as well as the relatively small sample size in this study—content analysis was chosen as an efficient and streamlined approach that would best assist the researcher in successfully accomplishing the goals established for this research project.

At the beginning of the content analysis process, the researcher carefully considers their research questions and reflects on what kinds of themes he or she might anticipate will emerge from the narrative data. The researcher broadly examines the narrative document with the goal of noticing and noting in the margins general sentiments or interesting or relevant information. From this initial process, the researcher might develop a category and record it in a separate document. The researcher continues to review the document in this fashion, developing categories that become known as a coding structure. When the categorization process is exhausted, the researcher then begins a line-by-line analysis of the text.

Researchers conducting a content analysis continue to ask questions throughout the analysis process in order to better understand the data. Strauss and Corbin (1998) organized questions into three categories: (a) *sensitizing* questions, (b) *theoretical* questions, and (c) *practical* and *structural* questions. In content analysis, the researcher uses sensitizing questions in an attempt to determine what the data might be indicating. For example, using the content analysis methodology, the researcher might ask: How do the participants define the situation and what meaning does it have for them? In addition, *theoretical* questions are asked to assist the researcher to make connections between concepts and examine the process and variations that may or may not exist. For example, the researcher might question the relationship between one concept and another or might

be curious about how outside situations may factor into or influence a participant's response. In content analysis, *practical* and *structural* questions are addressed by the researcher at the end of the study.

In the coding process of content analysis, the researcher begins by identifying potential categories, or descriptors of data, and developing narrative descriptions of such categories (H. Schneider, personal communication, April 4, 2011). Categories, otherwise known as themes, are further divided into major and minor groupings (otherwise known as categories and subcategories) and are compared and contrasted with one another with the goal of developing "the big picture." In this phase, the researcher decides whether a collection of data constitutes a new and unique category, or whether it is similar to and fits within an already existing category. This procedure is similar to the development of subcategories in Strauss and Corbin's (1998) *axial coding* process except that in content analysis, the reassembling of data is performed later in the process once all the data has been coded and grouped according to categories. Content analysis is complete when *all* the data has been coded.

Content Analysis Procedure for the Study

Content analysis for this study began with a comprehensive review of each transcript. Relevant or interesting information was noted in the margins of each transcript, and this information was later organized into a coding structure that was created using a separate document. This coding structure provided the basic scaffolding to begin outlining common categories found across narratives. For example, the category termed "initial impressions" was developed based on subjects' comments about their thoughts and feelings at the beginning of the workshop. This category was then assigned

a descriptor (“INITI” to stand for initial impressions) and a number (20000). All sentiments that reflected participants’ initial thoughts and feelings about the workshop were coded within this descriptor. Statements that were not the same but seemed related were placed in a subcategory with a corresponding number. For example, some participants expressed concern about beginning the workshop whereas others reported more positive feelings. Two subcategories were therefore created underneath the larger category of “therapy relationship” to capture these sentiments. Once a list of categories was generated, they were examined to determine whether any of the categories could be linked. If so, they were either listed as major categories or minor categories. These categories were re-examined to determine whether they were, in fact, assigned to the correct category or whether they should have alternatively been placed into a different category.

Once the coding process was complete and all relevant data was assigned and electronically grouped into documents according to numeric and descriptive categories, the original copies of the transcripts were reviewed one final time. Text that had been previously excluded in the coding process was re-examined to determine whether it was relevant and should be included in the results. Once all comments were grouped into separate documents according to their specific category, the researcher began a theme analysis. For example, each comment in the “initial impressions” category was reviewed in a line-by-line fashion to identify specific themes. In this way, it was discovered that participants’ familiarity with other group members impacted their initial feelings about the workshop and being part of a group.

One of the weaknesses of content analysis is that it is dependent on the analyst's interpretation, and therefore, subject to bias and prejudices. This concern can be partially mitigated by intercoder reliability. For this reason, following the development of the coding structure, one outside reviewer was recruited to code all 11 transcripts (for specific instruction given to raters see Appendix G). If additional categories emerged in this process, the coding structure was adapted until transcripts could be coded without further additions to the coding structure. Additionally, another outside reviewer was asked to examine the comments placed in each individual category and give descriptions of any themes they came across as they read through the data. The list of themes and subthemes from the outside reviewer was contrasted with the list developed by the researcher to ensure objectivity. The final list containing the themes and subthemes from the data was determined through the collaboration of the outside reviewers and the researcher. A total of 26 themes and 24 subthemes were identified and organized into seven broad categories entitled: Motivation for Participation, Initial Impressions, Expressive Arts, Storytelling, The Power of Witnessing, Impact of the Healing of Memories Workshop, and General Thoughts.

Chapter IV: Results

This chapter will present the results of the content analysis of interviews of eleven participants who participated in a 2-Day Healing of Memories Workshop held at a graduate school in Berkeley, CA. The majority of the participants were enrolled in a clinical psychology doctoral program and were concurrently working in the mental health field as part of their training. Research findings from the interviews in the form of derived themes and subthemes are presented in this chapter. It will be remembered that the purpose of the interview was to determine which aspects of the workshop participants found central to their healing process and evaluate the HOM as a collective trauma treatment for subclinically traumatized populations. Actual quotes from the interviews are used when possible to allow the voices of individual participants to be heard and allow for a richer description of the themes and subthemes being presented.

A total of 26 themes and 24 subthemes emerged from the interview data. These themes are grouped and presented within seven categories. Although the initial coding structure used 37 preliminary categories, these categories have been collapsed into seven broad categories for purposes of simplification. In order to constitute a theme, two or more participants needed to support a particular idea or sentiment. Within the presentation of themes, subthemes endorsed by two or more participants are discussed to enrich and further elaborate the description of each theme. To facilitate readability, categories are lettered A through G, and themes are numbered 1 through 26. See Table 1 below for a brief summary of the themes within each category. In the text description of each theme that follows, more elaborate wording is used to describe themes so as to more closely capture the sentiments expressed by the participants.

Table 1

Interview Coding: Categories and Themes

<i>Category</i>	<i>Theme</i>
A. Motivation for Participation	1. Variety of Issues to Address 2. General Curiosity 3. Impact of Faculty Presentation 4. Adjunct to Individual Treatment
B. Initial Impressions	5. New Versus Unknown Acquaintances 6. Group Composition's Impact on Feeling Safe
C. Expressive Arts	7. Variety of Approaches 8. Rituals Facilitate Reflection, Integration, and Healing 9. The Role of the Group
D. Storytelling	10. Prior Experience of Telling One's Story 11. Concerns About Sharing 12. Emotional Response to Sharing 13. Looking for Commonalities While Listening 14. Mixed Feelings Toward Participants' Nondisclosure
E. The Power of Witnessing	15. New Experience That Facilitates Healing 16. Creation of Intimacy and Closeness 17. Humanization
F. Impact of the Healing of Memories Workshop	18. Release of Negative Emotions 19. Creates Perspective 20. Reconnection 21. Appreciation For the Experiences of Others 22. Subtle Shifts 23. Curiosity About Using the Workshop in Other Contexts
G. General Thoughts	24. Simple and Accessible 25. Appreciation for Workshop Being Offered at School 26. Would Recommend to Others

In Category A, Motivation for Participation, four themes emerged: (a) the participants had a variety of issues they were hoping to address; (b) the participants were curious about what would surface for them emotionally in the process; (c) many of the participants decided to enroll in the workshop after hearing a faculty presentation; and (d) some individuals chose to participate, believing that the workshop would supplement their individual therapy.

Category B, Initial Impressions, produced two themes: (a) being acquainted or not with the other participants and (b) having mixed feelings about the composition of the large group.

Category C, Expressive Arts, contains four themes: (a) the different ways participants approached the expressive arts and ritual activities; (b) the role of nonverbal and tactile activities as a means to draw out the participants' emotions; (c) the ways in which expressive arts modalities facilitated reflection and healing; and (d) expressive arts as a medium to support unification and collaboration between participants.

In Category D, Storytelling, five themes emerged: (a) prior experience telling one's story; (b) concerns about sharing and disclosure; (c) emotional response to disclosing; (d) a strong interest and desire to find commonalities and similarities while listening to others; and (e) mixed feelings toward some group members' lack of disclosure.

Category E, the Power of Witnessing, produced three themes: (a) mutual witnessing as a healing experience; (b) the role of witnessing in creating interpersonal intimacy; and (c) the process of humanization.

Category F, Impact of the Healing of Memories Workshop, contains six themes:

(a) the release of negative emotions; (b) the participants' process of beginning to see their story differently, both within a larger context and with more perspective; (c) a regained sense of connection to others; (d) a gained appreciation and empathy for one's own experience, as well as the variety of all human experiences; (e) the nature of change; and (f) the participants' curiosity about the utility of the workshop model in other contexts.

Category G, General Thoughts and Impressions About the Workshop, has three themes: (a) the participants' reactions to the simplicity of the workshop as an intervention tool; (b) the participants' appreciation of the workshop being held at participants' graduate school, and (c) whether the participants would recommend the workshop to others.

Category A: Motivation for Participation

This section contains themes related to the participants' reasons for enrolling in the workshop, including expectations for what they might gain from participation. In addition, the researcher asked them specifically whether their decision to enroll in the workshop was spurred by a desire for healing or support around specific issues.

Theme 1: Variety of issues to address. Four participants stated that they had enrolled in the workshop because they were anticipating something specific or transformative to occur. In this vein, several participants disclosed recent transitions and losses that had occurred in their lives and stated that they hoped that their participation in the workshop would allow them to process unresolved feelings of grief and pain.

Participant 7 had recently relocated to attend graduate school:

I was just going through an adjustment. I never lived anywhere outside of [where participant was born] in my life.... I moved here and so that was a little bit

traumatic and a culture shock.... I was going through something in the present and also adjusting back to graduate school on a doctorate level.... All those things came together and that's why I did the healing workshop.

Three participants admitted to feeling “stuck” and unable to move forward in their lives. They each expressed the hope that attending the workshop would serve as a catalyst that would allow them to move forward. Participant 4 stated, “I was struggling with my dissertation, and I thought there was something there that could be linked to just unresolved grief.” Participant 7 echoed this sentiment: “A lot of things were getting in the way of me doing my work.”

Theme 2: General curiosity. Three participants acknowledged being curious about what might surface for them emotionally during the workshop as well as what they might learn about themselves during the experience. Participant 8 remarked,

I was more interested in seeing what was coming up. I think my issues about my past feel somewhat vague, and I can identify some areas. I was hoping to have things emerge and then have those areas probably be more solid.

Similarly, Participant 5 offered, “I went in[to the workshop] thinking, all right, what are you guys going to get from me that I didn't know was there?” Participant 11 echoed the same sentiment: “I thought I would show up and see what popped up.”

As noted above, most of the participants were doctoral students in a clinical psychology program. Several of the participants expressed an interest in learning about the workshop as an alternative form of therapy. These participants expressed a curiosity about whether aspects of the Healing of Memories workshop might be useful in other settings, including their work with different patient populations. This connection to their clinical practices was best expressed by Participants 4 and 10. Participant 10 noted:

I felt this was a really good chance to go through a certain experience and learn more about it to see if it was applicable to the kind of populations that I'm interested in. So I just jumped in and did it in the hopes of being trained in it.

Similarly, Participant 4 reported, "I was actually working with grieving people at the time, and I thought it would be really interesting to see something else that was done to help that process besides the modality I worked with."

Theme 3: Impact of faculty presentation. The participants heard about the workshop by e-mail, flyer, or faculty presentation. Three participants had been very impressed by a presentation they had attended on the Healing of Memories workshop that had been conducted in South Africa. For these participants, their decision to enroll in the workshop was directly linked to this lecture. Participant 6, who was one of the participants who had attended this presentation, expressed [her] impressions in this way:

[Healing of Memories] seemed like a really powerful program, and I was really taken by the video that [the presenter] showed and that the experience seemed really transformative for a lot of the participants, both individually and in relation to other people.

Participant 8 endorsed a similar sentiment: "I think the thing that most struck me was hearing [the presenter] present his Healing of Memories work during a lunch session. And he not only talked, but he had a video of the work that was done in South Africa."

Theme 4: Adjunct to individual treatment. Three participants reported being simultaneously involved in their own individual psychotherapy while attending the workshop. Many of the participants reported that their individual therapy was helpful; however, other participants expressed a greater interest in collective healing and processing; that is, working through their issues with the support of a group. Other participants expressed this ambivalence more subtly, noting that they felt that something

was missing from their individual therapy that they were hoping to get from a group therapy experience. Participant 10 remarked:

I had started doing a lot of personal processing about my past, and “forgiveness” was a big thing that was talked about in Healing of Memories. I think that was a big part that I needed and hadn’t really gotten into in my therapy yet, hadn’t really forgiven a lot. And so I was just thinking that it would benefit me in that way to process this collectively in a different way that wasn’t like my one-on-one therapy, in hopes that it would steer me toward forgiving what I needed to forgive.

Participant 7 felt similarly, stating simply, “I was going to therapy, but I knew that I needed something a little bit extra.”

Category B: Initial Impressions

This section presents the participants’ initial thoughts and feelings at the beginning of the workshop, and in particular, their feelings about the group composition and its impact on their initial sense of safety.

Theme 5: New versus unknown acquaintances. When addressing their initial impression on joining the group, several participants referenced other group members. Participant 10 disclosed that she appreciated not knowing the other participants prior to the workshop because of the anonymity this afforded her. Conversely, other participants expressed feeling anxious and vulnerable in the company of “strangers.” In fact, not being acquainted with other group members prior to the workshop brought up feelings of vulnerability for many of the participants, and they struggled with deciding how much to reveal and whether they could even trust the other participants. Several participants remarked that not knowing the other participants led them to feel “disconnected” from them during the first evening, and they were doubtful about whether real relationships could be formed within this context as well as what other participants would be able to

offer them, if anything. Participant 9 described it this way: “There was this kind of disconnect. There was no common ground.” Participant 8 stated, “I think with any new group, I feel initially kind of anxious or hesitant, or the fears come out.... Is this going to be safe, and can I trust each of these people? Can I trust this group?”

Although several participants endorsed feelings of apprehension and discomfort at the beginning of the workshop, it is noteworthy that these participants also felt that this initial discomfort dissipated over time, and they became increasingly more comfortable as the weekend progressed.

While some participants felt more comfortable with anonymity, other participants felt a sense of safety by being acquainted with other group members, and they even expressed being excited that they would get to know these participants in a deeper and more intimate way. This sentiment was expressed by Participant 6 as: “I remember feeling excited thinking that there were a number of folks from my [school cohort] that were there and excited that I would get to know them better.” Other participants found almost immediate connections or similarities to other group members, even though they were meeting them for the first time. Participant 3 explained:

We did some kind of introductions, and the woman that I was sharing with did Middle Eastern studies in undergrad, and I am very interested in the Middle East, so there was immediately some kind of a common interest. It seemed that with a lot of people, there was a connection that they immediately found.

Similarly, Participant 4 found an immediate connection to another group member because she saw an earlier version of herself in her: “One of [the group members] reminded me of me at the beginning of [this program], so that was sort of endearing. And the other one just seemed pretty approachable, so I felt comfortable.”

Theme 6: Group composition's impact on feeling safe. The majority of the participants interviewed commented on the composition of the group and its impact on their initial feelings of safety. Participant 5 appreciated the diversity of age, race, and experience that comprised the group, while Participant 9 felt exactly the opposite, noting that she was “frustrated because [she] was put in a group with one student that was in [her] cohort and then three professionals who had no ties to [the school] and whom [she'd] never seen before and who weren't really students.” Participant 8 took issue with the age disparity of the group: “There was an age thing that made me feel a little bit nervous.”

A few participants disliked the mixture of students and professionals. Some participants voiced concerns that the majority of the facilitators were also instructors at the school where the workshop was being offered. Conversely, Participant 3 specifically stated that she appreciated the fact that the facilitators were also active participants in the process. In a similar vein, Participant 11 viewed the workshop as an opportunity to become better acquainted with his instructor, while several other participants worried about sharing personal information with the facilitators who were also instructors and might someday be evaluating their performance.

Participant drop out had a significant impact on the remaining group members. Four participants expressed concern when they realized that a few participants had failed to show up on the second day. This concern was articulated by Participant 7:

I think what was not so safe was the second night when some people didn't show up, but they showed up the first night, and I was like, “Oh crap, they know this little piece about me. Are they going to go say something?” The inconsistency, I think, was what got to me.

Category C: Expressive Arts

This category addresses the participants' experiences and reactions to the expressive arts portion of the workshop. These activities included (a) drawing one's story, (b) a burning ritual, (c) creation of a clay peace symbol, and (d) a group performance and celebration. Themes in this section center around (a) the participants' subjective experiences and approaches while participating in these creative processes, (b) the perceived value of these expressive arts interventions in deepening the participants' emotional experience, and (c) the collective nature of these activities.

Theme 7: Variety of approaches. The first expressive arts project was drawing one's story. The participants approached this project in a variety of different ways, ranging from abstract and circular or nonlinear to concrete and chronological. Some drew their story symbolically, while others approached the process more concretely, writing down words, phrases, or memories.

Many participants were familiar with the use of art and other creative processes, and they reported engaging in such activities in their personal time. These participants were excited and appreciative that these modalities were being implemented as part of the workshop. Participant 4 described her familiarity with drawing and stated, "I went into the process of drawing very easily, but I also do that every week. So that was really enjoyable. It came out very easily and felt like things were placing themselves."

For those who did not consider themselves to be "artistic," however, these activities were accompanied with feelings of anxiety and frustration. In the words of Participant 10, "I'm just not an artistic person, and so I really struggled with that.... I just could not get it right, and that was really frustrating for me.... I didn't like that part."

Still other participants were surprised by their creativity and believed these activities helped them to learn something about themselves that they had not previously known. As Participant 7 put it:

I just thought the coloring was beautiful, and I looked back, and I was like, “Wow, this is pretty good.”... People were impressed with it. I was like, “Wow, I have a creative side that I really didn’t tap into.” I totally did not know I could be that creative.

Theme 8: Rituals facilitate reflection, integration, and healing. Several participants felt the expressive arts activities allowed them to enter into a meditative state and believed the nonverbal and tactile components of these activities facilitated a deepening of their emotional experience. In the words of Participant 2, “I think there’s always a lot of unexpected things that come up when you stay out of your mental realm, and I really appreciate those insights or emotions that come up when you are outside of your mental process.” This deepening of the participants’ emotional experience allowed them to come into closer contact with their stories, enabling them to notice and reflect upon patterns as well as places where their story was incomplete. Participant 11 noted, “[The drawing] helped me to be conscious of all the different pieces of my life that were there.” Participant 3 felt similarly, stating: “It helps to think about patterns over long periods of time.... You are able to see stuff repeating, and it’s easier to see on paper—for me at least.” Participant 11 put it this way:

The clay things somehow was a way to express my own inner vision of my own life ... something that probably I had inside of me but it wasn’t concrete.... To put it in clay as a sculpture made it seem concrete. It allowed me to see it in a different way.

Seeing one’s story in a different way can create the opportunity for deeper reflection, which can facilitate new ways of thinking about the past as well as one’s own

story. In this way, the workshop participants can begin what some narrative therapists refer to as a “reauthoring of one’s story,” that is, shifting from a focus on the past to a new focus on desired directions and possibilities for the future.

For three participants, the clay peace symbol represented a personal hope for the future, or it was symbolic of the overall theme of their life. As Participant 6 put it, “It felt like on this very intentional and deep level that I crafted my clay in terms of who I want to be and how I want to be.” Participant 7 echoed this sentiment and stated, “[The clay] embodied who I want to be going forward.” It is noteworthy that most of the participants felt deeply connected to the objects they had created. Five participants decided to keep their drawing or clay object, stating that they felt a sense of pride at what they had created and also that they appreciated the symbolic meaning of their creations. Three participants displayed these objects in their homes and said that they often look at them to reflect upon, and be reminded of, the shifts and changes they made during the workshop.

The burning ritual also contributed to the healing process. The participants generally claimed that the experiences provided the space to release some of their more painful and difficult memories, and they used words such as “cathartic” and “healing” to describe their experiences. Participant 7 noted, “[The burning ritual] was an amazing experience. I didn’t think that that little gesture was going to be that impactful.... I felt this sense of relief, like everything’s gone and it’s going to be okay.” Participant 10 summarized her experience of participating in the burning ritual this way:

I wrote a lot on my piece of paper, just all the things that I have held onto—blame and negative feelings that I realize I can’t control anymore. It felt really nice to burn it, and it felt nice to do it all together.... It was just a really calming kind of experience.... It made me feel at peace with the decision to try at least to let go of these things that have been with me for a long time. It felt really cleansing.

Theme 9: The role of the group. Five participants spoke about the impact of participating in expressive arts in a group environment. Although drawing one's story and creating a clay peace symbol were both solitary activities, per se, they were created within the company of the other group members.

However, the burning ritual and the final performance were experienced as a group, and all the participants concurred that these rituals were unifying experiences. In the words of Participant 3:

[The burning ritual] had a kind of tribal feel to it.... The fact that everybody did it and that everybody had something that they wanted to let go of was somehow unifying.... It was just empowering because we created some connection and we had a chance to do something with it like create this group celebration.

Participant 11 appreciated the involvement of the group during the burning ritual and stated, "It was nice for me to have the group involvement with [the burning ceremony]—having everybody stand around and do that."

The final celebration was also a group activity, and several participants appreciated having a celebration to mark the end of the workshop. Nonetheless, each group member had a different experience of it. Participant 3 felt that people dispersed too quickly after the celebration. A few participants expressed an appreciation for having a more joyful and collaborative space on the final day. In the words of Participant 4, "The day before [the ceremony] was very emotional for all of us, but the day after was just so much more joyful. I think we got to participate at a different level. I think there was a lot of release." Participant 1 agreed: "I think that having an informal thing at the end was nice because it felt like a conclusion or a positive way to let it out."

Category D: Storytelling

A number of themes emerged from the participants' stories. These themes included (a) whether participants had ever told their story in this way, (b) anxieties or hesitations that came up about sharing their stories, (c) the desire to find similarities in their experiences, and (d) a sense of frustration by some of the participants that some group members had not been as open as they could have been.

Theme 10: Prior experience of telling one's story. As previously mentioned, several of the participants were in their own individual therapy at the time of their participation in the workshop. The responses were mixed in terms of whether participants had told their stories before: Some participants reported that they had discussed their story with their therapists or other close friends, and others reported that there were parts to their story that they had never disclosed to anyone. This was the case with Participant 8, who stated, "I never told my story in that way before, and I've been, and am currently in therapy." Regardless of whether the participants had had the opportunity to tell their story, the majority of them reported never having had the opportunity to tell their whole story without interruption. Participants 1 and 10 shared that they had only told their story in "bits and pieces." Participant 10 explained, "I had told people my story, but I don't know how often it was like that ... starting from the beginning and going to where I am now. Maybe it was just sort of bits and pieces before." Participant 1 echoed this experience: "When you are telling [your story] to a friend, you are not sitting down and saying here is point A to point B to point C." These statements are reflective of the common ways in which the stories and traumatic memories of victims have the tendency to become fragmented, especially when they have

deliberately been silenced, or their stories have remained unspoken. That is, without the opportunity to develop a complete and more coherent narrative, painful memories or aspects of one's experience remain stored within one's body.

Theme 11: Concerns about sharing. Seven participants expressed concern about telling their story. Two participants were apprehensive because they feared that they would be burdening other group members. Participant 7 said:

I felt a little bit bad because I felt like I'm leaving everyone with this stuff that I just revealed. I hope that they can handle it; I hope it's not going to mess up their day.... I felt guilty putting my problems out there for these people to carry.... I felt like I was burdening them.

Three other participants expressed anxiety about how their story would be received by others and felt "emotionally vulnerable" while disclosing what was very personal to them. Participant 8 explained, "I think I am always sort of hesitant to share [which in part is because of] the fear and the anxiety that comes with sharing your story or sharing something that's challenging—fearing judgment and rejection."

Theme 12: Emotional response to sharing. Five participants spoke about the "comfort" and "relief" they felt during and after sharing their story. Participant 7 summarized her experience in this way: "I felt this huge sense of relief.... It felt good. It felt like a huge weight was lifted off my shoulders." Participants 6 and 10 were surprised by how much they disclosed and how emotional they became during the sharing process. Participant 6 recalled:

I think I cried at one point, and that was surprising to me, that I would cry, because I feel in a pretty steady place. So remembering something that had happened to me when I was a teenager, I was curious that that would evoke tears still at this point.

Participant 10 also reported becoming emotional during the storytelling process: “In that moment my emotions were running the show.... I was really emotional.”

Theme 13: Looking for commonalities while listening. While listening to the other group members tell their story, several participants remembered actively looking for similarities to their own story. Participant 11 recalled, “I was looking for commonalities. I was looking for how does that overlap or crossover with my life, and how might that be similar to try to find that connection?” For those participants who had yet to share their story, hearing the other participants’ similar experiences gave them courage to share their own. Participant 8 explained it this way, “People sharing things that were honest and/or people getting emotional, which is honest, helped me feel more safe, and I think allowed me to share.” According to Participant 10, “One of the girls had a similar upbringing—a little more chaotic I would say.... She really opened up about it.... It just made me feel more comfortable to be able to go there, too.” Participant 7 echoed this sentiment:

I think when other people revealed their traumas, and one revealed a trauma that was very similar to mine, [it gave me courage].... We actually became very close friends after that experience.... I think seeing everyone else’s vulnerability helped me get my stuff out.

Theme 14: Mixed feelings toward participants’ nondisclosure. Two participants expressed frustration with a few of the participants’ stories, feeling that these participants were holding back and not being open or sharing as much as they could. This holding back of a few interfered with the other participants’ ability to feel close to them and connect with their stories and experiences. This sentiment was expressed by Participant 3: “I was annoyed with one of the participants in my group who wasn’t sharing all that much. He was really staying on the surface.... I don’t think I could quite

connect with him.” Participant 7 echoed a similar sentiment, remarking that a member in her group “didn’t share anything, she danced around things.... It was like she was speaking from a textbook.” Conversely, however, two of the participants expressed empathy and compassion for those participants who were not willing or able to disclose as much as other members of the group. Participant 5, who had initially been frustrated with another group member’s “talking around” issues rather than speaking about them directly later found compassion and understanding for this participant’s limits and stated, “I remember thinking that for her this might be a step up.”

Category E: The Power of Witnessing

Mutual witnessing can be very powerful. In this theme, the healing nature of this experience was explored, as well as the closeness and intimacy that is created between group members during this type of process and the humanization of the “other” that results from these interactions.

Theme 15: New experience that facilitates healing. Five participants remarked that they felt validated by the others who had witnessed their story. Participant 5 noted, “My parents didn’t really give me a lot of validation.... And that’s exactly what it felt like in the room.... I haven’t had [validation] in a while.... I have to say it feels really good.” Participant 10 felt similarly: “It felt really validating to just have the undivided attention of four other people.... The theme was that we [the group members] didn’t have that support before.” For many, experiencing this kind of support and attention from others who were relative strangers was a new and surprising experience that left a strong impression. Participant 8 explained, “Telling my story and having people validate it and

listen to it.... I could see from their faces that they were engaged, or felt it [my story].
That was really powerful.”

Theme 16: Creation of intimacy and closeness. Five participants spoke about the bonds and connections that were created between group members during the process of mutual witnessing. Participant 6 commented, “When somebody tells you or trusts you with their story, it’s like this intimacy is developed.... Even if I haven’t been through any of the stuff that you’ve been through ... in the telling we’re creating intimacy.” Several participants also spoke about the role of empathy in being emotionally connected to other members of the group and how this differed from their initial impression and reservation at the beginning of the workshop. Participant 9 explained:

Once we shared out stories and we drew them, we went from having no common ground to an emotional connection where I was able to empathize, and that definitely made me feel excited about the group I was in versus the initial “Ugh, I don’t know any of these people.”

Theme 17: Humanization. Five participants described how hearing other participants’ stories made them feel a sense of connection to humanity, and this prompted them to rethink the assumptions they commonly make about others. Participant 8 remarked:

[The storytelling process] made everybody in my group more human to me and made me realize how much I project and/or just assume that, because of the way you look and dress, you are xyz.... It’s not that black and white. [One participant’s] story was a very different story from what I’ve seen in the media, and that also changed my thinking.... [Hearing others’ stories] made the person more rich and nuanced and human.

Participant 7 felt similarly:

One person, the one I grew close with, I was in two classes with her.... I had preconceived notions about her, I judged her. We all do that, right? And for her to be so vulnerable and everything that just totally flipped the script. It just totally changed everything.

The participants noted how seeing the humanness of others influences the ways in which they view the world. Participant 6 explained:

Whenever I am reminded of our humanity and what that really means, I walk around the world different. I don't see that asshole that cut me off in traffic, I see someone who has their own whole complex life full of stories and sorrows.

Category F: Impact of the Healing of Memories Workshop

All of the participants were strongly impacted by the healing and cathartic nature of the experiences in the workshop. They identified a number of ways in which they were impacted. These included (a) seeing their story from a different perspective; (b) feeling reconnected to others, their community, and themselves; (c) appreciating the diversity of human experience; and (d) appreciating the small shifts that occurred as a result of the experience.

Theme 18: Release of negative emotions. The majority of the participants described the feeling of “letting go” of painful experiences and emotions, such as guilt, fear, and responsibility. However, in discussing the healing they believed took place in the workshop, they were often unable to put their experience into words, and thus, often described their experiences in more physical terms, such as “less heavy,” “more solid,” and “more grounded.” As Participant 1 put it, “I don't know that I can really explain it verbally, but I think it's like less heaviness, and I know that's a very physical description.” As noted earlier, some of the participants had enrolled in the workshop hoping for change, while others considered the workshop to be just another step along their path toward healing. Participant 4 had this to say about her experience:

There is this solidity to the change that wasn't there before. So [the workshop] left me feeling more solid that I was going in.... Feeling more solid meant being less stuck.... I felt lighter on my steps, and I also felt more centered.

Theme 19: Creates perspective. A number of the participants' experiences helped them to gain perspective and think about their story in a different way. These experiences included (a) telling one's story to a witness, (b) noticing similar themes while listening to others' stories, and (c) using expressive arts. This new perspective allowed them to put distance between themselves and the painful experiences, thus being able to see their story or problem within a larger context, and thereby let go of their feelings of self-blame, burden, and responsibility. Participant 4 articulated this well: "There is something about hearing echoes of my story elsewhere that got me to feel that it was less done to me, but done, and I was there as well." Participant 8 felt similarly:

I feel like I have a more distant perspective on it. So rather than being in it and really internalizing it all as something wrong with me, there's a little bit more of a distance in saying, "Wow, there's this context of shit happening."

Also, seeing that others have gone through similar experiences facilitated a shift in how the participants viewed themselves in relation to their story. Participant 4 remarked, "Because I got to see that there were more people impacted by similar things, it made me feel like less of a victim."

Theme 20: Reconnection. The overall consensus among the participants was that the Healing of Memories workshop allowed them to connect with themselves as well as with other people in a short period of time. A few participants remarked that the workshop had provided them the opportunity to get to know their group members on a deeper level and interact with them in ways they are often unable to do in their day-to-day lives. Participant 2 stated, "I feel like I got to know a little bit about people in a very intense short period of time. Sometimes you know people for years, and you don't know very much about them." Participant 5 remarked that the workshop provided her

with a safe space to connect with people of other genders and ethnicities. She explained, “With White women, I’ve had those connections, but I don’t think I’ve ever had [that connection] with a White male.... So that was a very real moment.”

A third subtheme that emerged was expressed by a few participants who stated that the workshop provided them with the opportunity for self-examination and reflection and resulted in an increased sense of self-awareness. Participant 6 believed the workshop helped her to “deepen my sense of self-examination,” while Participant 7 reported feeling “much more aware of my behavior and my way of thinking.”

Theme 21: Appreciation for the experiences of others. Five participants believed that listening to others’ stories greatly impacted their ability to empathize with, and have compassion for others, despite the differences in their experiences. Participant 3 remarked:

Everybody has some kind of a story, some kind of an impact that they experienced from society or whatever. So I just think the fact of learning other people’s stories creates the potential for empathy.... Once you know the story of the person, it is easy to be forgiving of them, or it is easier to be accepting of them, of their imperfections because you know their struggle, or you know that they are also struggling with something. There may be reasons why they are a certain way.

Participant 10 felt similarly:

I think I had this overwhelming appreciation for the individual’s story.... Each person in this world has an elaborate crazy story that you just don’t really think of.... You just see them in the car next to you, or they just cut your off, you don’t really put it into perspective. I just remember walking away and just having this insane appreciation for every single person because of their experiences and the fact they they’ve gone through so much.

Theme 22: Subtle shifts. Several participants stated that the workshop had helped them move forward with their lives. Participant 5 described it as “smooth, subtle,

and real.” Most of the participants described a “shift” that had occurred, as opposed to being transformed in some way. Participant 11 described it this way:

[The workshop] doesn’t stand out as a changing point but I think at the very least there is some kind of shift or reconnection.... Whether that causes transformation I don’t know but there is something intensely connecting about the whole process.

In a similar vein, Participant 3 noted, “I don’t think it causes a radical transformation, but it definitely contributes to something, to some progressive change.” Participant 4 was having a particular conflict around a graduate school requirement and reported that the workshop had helped her to “get unstuck.” She explained, “There was no awakening or epiphany, I would say, but the emotional charge that I needed to move—where I had been in my head about it ... that emotional charge took place.” A few participants described the feeling of peace at the conclusion of the workshop. Participant 10 explained, “I remember walking [away from the workshop] down the street, and I noticed people ... and just like a feeling of peace and a feeling of happiness and a feeling of joy as I walked away from [the workshop].” Participant 5 added, “I can say that it’s one of those moments in my life that I’ll always remember—nice little warm and fuzzy inside.”

Theme 23: Curiosity about using the workshop in other contexts. Participant 3 and Participant 11 expressed a curiosity and interest about how the workshop might be used in different contexts and with different populations. During the workshop, Participant 3 became interested in applying the workshop’s concept to adolescents in juvenile hall. Participant 11, who was leading therapy groups for students at the time of the workshop, expressed an interest in exploring how certain aspects of the workshop might be adapted to work with students in school-based settings.

Category G: General Thoughts

This final category includes the general thoughts the participants had about the workshop that did not fit into the other categories. These thoughts included comments about (a) the nature and design of the workshop, (b) an appreciation that the workshop was being offered at the participants' graduate school, and (c) the fact that the participants would recommend Healing of Memories workshops to other professionals and students.

Theme 24: Simple and accessible. Three participants praised the Healing of Memories workshop model because it was simplistic and thus accessible to people who might not be interested in traditional one-on-one therapy. Participant 2 explained:

[The workshop] is a very simple idea, but it's a great way, I think, to access the emotional part of our lives.... A lot of people are not therapy oriented and don't feel comfortable with the idea of going to therapy.... I think this model really can be much more acceptable or accessible to people who don't want to do therapy.

Participant 11 agreed: "To be quite honest, on some level, the Healing of Memories feels quite simplistic, but I think it can be very deep and meaningful." Participant 2 was one of the few participants who was not in the field of psychology and not enrolled in a psychology doctorate program. She offered her opinion, stating, "What was so nice about this was that it is based some on psychological insights, but it's not just in the psychological realm or field." This researcher believes that this comment indicates that the workshop is an integrative intervention model that can potentially appeal to a wide variety of populations.

Theme 25: Appreciation for workshop being offered at school. Three of the student participants said that they appreciated the fact that the workshop was being offered through their graduate school and that the instructors who facilitated the

workshop also participated as group members. This conveyed to them that the workshop is both welcomed and highly valued. Participant 8 offered, “Professors were a part of [the workshop], and we were here at school, and that it’s valued here, I think, it says a lot to me, that it’s valued, that it’s okay.” Participant 10 also expressed appreciation for the facilitators’ involvement, stating:

I really appreciated the fact that it wasn’t hierarchical, and [the professors/facilitators] participated in it just as much as everyone else did.... And that’s kind of a rare thing to see in groups and therapy.... Everyone had things to work out and things to learn, even if they were the facilitator or the co-facilitators, so that was really cool.

Theme 26: Would recommend to others. Overall, the participants had a positive experience and said that they would highly recommend the workshop to others. Participant 10 stated, “I still have a tremendous amount of respect for the workshop, and I would recommend it to a lot of people.” Participant 9 added that she wished the workshop could be adapted and offered as an elective or a course at the school. Several other participants expressed a desire to continue their involvement with the workshop and even expressed an interest in undergoing training to become facilitators.

Chapter V: Discussion

Overview

By way of summary the current study investigated participants' experience of a Healing of Memories workshop in order to identify those aspects of the workshop that participants found central to their experience of healing. A goal of this researcher was to evaluate whether the HOM workshop or aspects of it could be used as an intervention with those who suffer from traumatic experience and present with subclinical trauma symptoms.

In this chapter, the study's purpose as well as key research questions are reviewed. The emergent themes of the trend analysis are summarized and discussed according to the following six broad categories: (a) motivation for participation, (b) initial impressions, (c) expressive arts, (d) storytelling, (e) the power of witnessing, (f) the impact of the Healing of Memories workshop, and (g) general thoughts about the workshop. Given that there is little previous research on the impact of HOM workshops, when possible, research results are discussed within the context of trauma literature that is closely related to the topic and was reviewed earlier. In addition this chapter outlines the clinical implications of the study, as well as its limitations and suggestions for future research.

Category A: Motivation for Participation

The first finding is that the participants who sought participation in this workshop did so with the motivation and desire for personal change and healing. Some participants had more specific or more conscious traumatic experiences that they hoped to process, whereas others were attracted to the workshop out of "curiosity," and were interested in

seeing what would surface for them in the process. It is possible that participants in the latter category may also have suffered underlying trauma that had been, for adaptive purposes, dissociated or pushed out of their conscious awareness. Such unrecognized trauma has been referred to in the literature as *constriction*, that is, as a protective and self-defensive state that functions to keep traumatic experiences and memories out of conscious awareness (Herman, 1997). Herman emphasized the ways in which these defenses serve to protect the individual from overwhelming emotional states; however, at the same time, they serve to prevent the integration of these experiences, which are necessary for healing. Ultimately, such repressed trauma impacts the individual's quality of life and perpetuates the traumatic effects.

Although some participants enrolled in the workshop in order to address recent transitions or losses that had occurred in their lives, several spoke about feeling “stuck” and unable to move forward for reasons unknown to them. Levine (1997) described how trauma symptoms, when unaddressed, can remain frozen within a person's body and may appear suddenly when faced with stress or the presence of another traumatic event. This may eventually lead to a breakdown. One participant, for example, described her struggle with writing her dissertation at the time of the workshop and stated that she believed that this difficulty was linked to “unresolved grief.” Similarly, another participant was having difficulty adjusting to graduate school and described this transition period as both “traumatic” and a “culture shock.” Since the majority of study participants were graduate students, the stresses associated with graduate school, combined with other life stressors, may have stimulated past unresolved traumatic symptoms, and thus, served as catalysts for their decision to enroll in the workshop.

Another interesting aspect of the study findings regarding participants' motivation for attending the workshop was a feeling that "something was missing" in their one-on-one therapies. For this reason, several expressed curiosity as to whether collective treatment methods, like the HOM, might heal aspects of their experience that had gone unaddressed in individual treatment. This is an interesting finding in that trauma tends to negatively impact one's connection to others and to the community (Herman, 1997), and, that many who suffer from traumatic experiences often feel that others cannot empathize with or understand their suffering. Thus, they tend to remain silent, and, as a result begin to feel disconnected, and unable to experience closeness or intimacy (Richman, 2006). While one-on-one therapies may be helpful in addressing trauma and trauma-related symptomatology, collective treatment methodologies might be especially effective in restoring victims' connection to others and to their communities (Diller, 2011; Levine, 1997). It is in this context that Herman (1997) discusses the use of group work in the later stages of treatment in relation to rebuilding trust and connection with others.

Lastly, a faculty presentation about HOM work in South Africa seems to have had a significant impact on many of the participants' decision to enroll in the workshop. For these participants, seeing the powerful and transformative nature of HOM's work on film stimulated an interest and desire to participate in such a workshop. While this theme does not provide direct information about the workshop as a healing phenomenon, it does offer valuable direction about how the workshop may be presented in the future to engage prospective participants.

Category B: Initial Impressions

Two themes emerged in this category, both related to the importance of group composition in creating a safe and containing workshop environment.

Initially, most participants reported feeling anxious and vulnerable in the company of other group members who they perceived to be “strangers.” Some in addition questioned how much of their story they should disclose, and whether they could trust other members of the group. Such reactions are supported in the literature: individuals with trauma histories tend to report difficulties in trusting others (Herman, 1997).

The diverse composition of the group membership initially concerned several of the participants because they feared that they would be unable to connect with others in the group due to a lack of perceived similarity or common ground. The literature also validates the existence of such fears and anxieties as common responses among trauma victims when placed in novel or unfamiliar situations. Auerhahn, Laub, and Peskin (1993) also suggest that trauma destroys one’s capacity for empathy and ultimately impacts a victim’s ability to establish a link between self and others. Richman (2006) referred to this as “failed empathy.” Similarly, most victims believe that other people are unable to understand and empathize with their experience of suffering, which, as noted above, also results in isolation and a disconnection from others.

Participants who were already acquainted with some of the group members as classmates appeared to be more at ease in the presence of “strangers.” In fact, they were excited about the possibility of connecting with other members of their school’s community on a deeper and more intimate level. Others expressed mixed sentiments

about the fact that two of the group facilitators were also instructors at the graduate school they attended. Several liked the fact that the facilitators were equal participants during the workshop; whereas others voiced concerns about safety and confidentiality issues. For those who felt positively about the facilitators' dual roles, "mutual sharing"—that is, the fact that the facilitators self-disclosed and acted as full participants in the workshop experience—appeared to mitigate participant concern about power differentials and hierarchical dynamics. Such equal disclosure and participation by facilitators in the group process appeared to set a tone that each group member was equally engaged, invested, and vulnerable in the workshop.

The importance of mutual sharing and emphasis on equal facilitator participation are both emphasized in the HOM literature (Institute for Healing of Memories, 2010a). The HOM workshop model is based on the creation of a supportive and trusting environment, a necessary ingredient in the creation of safety, mutual sharing and eventually the release of painful emotions. Participants who did express concerns about the dual roles of the facilitators (i.e., who were also their instructors) questioned the potential repercussions that personal sharing and self-disclosure might have. Such concerns raise the question of the utility of using facilitators who also occupy other roles within the participants' community and its potential influence on participants' experience of safety, ability to share openly, and overall impact of the workshop. The present findings suggest that future research be carried out in relation to homogeneity of group composition as well as the existence of dual roles of facilitators within the HOM workshop.

Category C: Expressive Arts

Themes in this category focused on participant experiences of the expressive arts and ritual components of the workshop. These included the drawing one's story and creating a clay peace symbol exercises as well as participating in the burning what you would leave behind ritual, and the final group celebration.

The first theme that emerged in this category was the observation that the participants approached these activities in a variety of different ways. For some engaging in the expressive arts processes was a new experience, whereas for others it was both comfortable and familiar. Most participants enjoyed the process of drawing their stories and appreciated the freedom to represent their life journey as they chose. Such non-verbal exercises, in fact, provide trauma survivors a greater sense of control over the overwhelming experiences they have endured, and leaves them better able to face their traumatic past at their own pace (Richman, 2006). Many participants in fact approached the drawing one's story exercise with openness and creativity, and were able to construct objects in a more abstract manner and use symbols and representations instead of words and timelines. This experience also allowed them to begin to view their stories in alternative ways once they had been able to objectify and externalize them on the page. Similarly, Richman (2006) described methods by which creative and expressive arts activities, especially autobiographical narratives, can assist self-expression and help victims of traumatic experiences create a context for integrating their fragmented memories. Despite the seeming simplicity of such activities, many participants felt that they had discovered something new about themselves in the process. Their comments were reflective of the ways in which such experiential interventions can assist individuals

in reintegrating aspects of the self, while at the same time constructing a more coherent and cohesive narrative.

The second theme in this category highlights the role of rituals in facilitating reflection, integration, and healing. Several participants spoke of the meditative nature of engaging in expressive arts activities. Entering into a nonverbal space while engaging in tactile activities seemed to help ground participants in their own bodies which in turn allowed them access to a wider range of emotions and emotional experience. Within this space, the participants found help in connecting to their stories as well as beginning to notice patterns and places wherein their narratives were incomplete. This was an important finding in that research has shown that one of the factors that perpetuates trauma and trauma symptomatology is the inability to form cohesive narratives because of the fragmentation that occurs when one becomes compromised mentally and loses the capacity to symbolize as well as form lucid narratives (Laub, 2005; Tuval-Mashiach, Freedman, Bargai, Boker, Hadar, & Shalev, 2004). In this study, expressive arts interventions allowed traumatized subjects to move out of an exclusively intellectual realm and release some of the more painful emotions that had been stored somatically (Levine, 1997; Richman, 2006; van der Kolk & Saporta, 1991). This process was believed to set the stage for transformation, integration, and healing to occur.

Thinking about and seeing one's story represented in a ritual or art form facilitates new ways of identifying with one's past. Seeing one's story represented in an object outside of one's self allows for what narrative therapy theory refers to as "externalization," a the process whereby distance is created between one's problems and one's identity (Morgan, 2000). In this regard White and Epsen (1990) suggested that

externalization marks the beginning of a change or shift whereby individuals can begin to develop alternative and more positive stories, or what Mollica (1988) referred to as a “new story” of dignity and virtue, rather than of shame and humiliation.

This concept of externalization was further reflected in participants’ sentiments about the symbols they created. For many the clay peace symbols came to represent a concrete idea or hope for the future. Herman (1997) also discusses the optimism that is generated after *remembrance and mourning* have taken place. This represents the second stage of recovery when the trauma victims begin to direct their attention and energy toward the future. Several participants reported that they felt a deep sense of pride in what they had created and chose to display these objects in their homes. This subtheme in turn supports Richman’s (2006) belief that expressive arts have the power to transform something shameful and hidden into something of beauty and a source of pride.

A third theme in this category illustrates the importance of engaging in expressive arts collectively despite the fact that they tend to be highly individual activities. Many participants found the burning ritual and group celebration to be opportunities for participants to come together and create something as a group. Some participants described this experience as “unifying” and “empowering.” Each participant seemed to have something to release and throw into the fire during the burning ritual; many experienced it as normalizing as well as supportive of their healing process. Several participants also appreciated the joyful and positive tone of the celebration that took place at the end of the workshop. They commented that this celebration assisted them in transitioning from a deeply emotional and reflective space to one of excitement and optimism about the future.

Category D: Storytelling

Several themes emerged in this category in relation to the cathartic nature of speaking one's experience out loud and the role that the development of a narrative had in consolidating previously fragmented memories and experiences.

The first theme in this category, *prior experience telling one's story*, produced a variety of responses among the participants. While some participants reported having had prior opportunities to share their story with close friends or mental health professionals, the majority acknowledged that there were specific aspects of their story that they had not previously disclosed to anyone. This theme relates to an earlier theme, *concerns about sharing*, whereby several participants originally expressed a reluctance to share their story out of fear that they would be burdening other group members. Herman (1997) observed in her research that people tend to become fascinated, yet simultaneously discomforted, when confronted with the traumatic experience of others. Common responses are disbelief, avoidance, denial, and discreditation. Unfortunately, such sentiments leave victims feeling not only invisible, but also with a sense that their experience is too much for other people to hear or hold. Similarly, the participants in this study expressed concern about the effect their trauma story would have on others and feared judgment and rejection, which may have been the result of previously failed experiences of disclosure. As will be discussed later in Category E, having such fears disconfirmed in the presence of empathic witnesses, proved to be a pivotal and significant outcome of the workshop.

The trauma literature highlights that a number of studies have addressed the impact that fragmented memories and experiences have on one's ability to process

traumatic experience and heal from it (Boulanger, 2005; Richman, 2006; van der Kolk & Fisler, 1995; van der Kolk & Saporta, 1991). One remarkable finding from the present study was that the majority of participants had never had the opportunity to tell their story in its entirety and without interruption. This finding highlights the importance of creating a full narrative of one's trauma and putting words to one's experience of it. According to Herman's (1997) second stage, *remembrance and mourning*, the construction of a more detailed and complete trauma story allows victims to begin the process of reclaiming pieces of their history and making sense of their lives. For many of the participants in the present study, having a dedicated space in which to tell their stories in their own way, in full and without interruption, was a first-time experience.

For the majority of participants, sharing their story in the small group proved to be an emotional, yet cathartic, experience. Several were surprised that they became tearful when reflecting upon and sharing aspects of their story that had happened in the distant past. These participants' experiences correspond to earlier studies that have found testimony to be a form of catharsis (Cienfuegos & Monelli, 1983). Other studies have noted the tendency of victims of trauma to defensively dissociate or "forget" the details surrounding overwhelming and painful experiences, even though the feelings associated with these traumatic events remain stored within the individual's body on a sensorimotor level and in time manifest as symptoms or reenactments (Richman, 2006; van der Kolk & Saporta, 1991). The acknowledgment and processing of these feelings in the workshop resulted in the participants experiencing what Levine (1997) referred to as a "discharging process," wherein energy associated with one's trauma is released, after which the trauma victim is able to regain the capacity to self-regulate and heal.

The remaining two themes in Category D are related to the participants' experience of listening to others tell their stories and the impact that that degree of personal disclosure had on the listeners' capacity to be empathetic. Listening to group members tell their stories in an open, honest, and vulnerable way seemed to give courage to those participants who had yet to share. In addition, recognizing the similarities among the stories within the group provided participants a strong sense of validation, comfort, and safety. This was an important finding in the present study. Typically, shame and fear accompany traumatic events, and personal narratives of these events tend to be embedded with self-blame and guilt. Thus, the trauma victim often chooses silence and isolation over disclosure (Herman, 1997, Richman, 2006). Hearing that others have similarly experienced painful events has a powerful impact such that the listener is able to lessen feelings of personal responsibility, and thus minimize the impact of the traumatic experience on the victim's life (White & Epsen, 1990). In this way the small group environment offers solace and support from those who have had similar experiences (Herman, 1997). Participants in this study were able to draw upon the resources and strengths of other group members, which then allowed them to successfully begin the process of collective grieving. Through this process, a victim's humanity is slowly restored (Herman, 1997).

In stark contrast, a final theme that surfaced in this category was the disappointment expressed by several participants who felt that other members of their small group had held back and did not share as extensively as they could have. This perception seemed to frustrate these participants who felt they had made themselves vulnerable to the group by sharing openly and expected the same from other group

members. This study did not collect data on the degree to which each participant felt that they had openly and honestly shared their life experiences with the group, so it is unknown what impact such a lack of disclosure might have had on the storyteller and the witness. This is an important question, however, since mutual sharing and witnessing are both fundamental components of the HOM workshop process. One might therefore conclude that unequal sharing may negatively influence the quality of the connections that are formed within the group as well as the degree to which healing could occur. Although it was beyond the scope of this study, further exploration into the relationship between the degree of self-disclosure and participants' ability to heal may provide important insight into the HOM workshop model.

Category E: The Power of Witnessing

Three themes emerged in this category: the healing power of mutual witnessing, the intimacy that is created between group members as a result of the process of witnessing, and a humanization of the other, a process that encourages individuals to reflect upon their own prejudices and stereotypes and how these can dehumanize others.

A number of the participants felt validated by hearing others' stories and having others in turn bear witness to their experiences. For many having such support was a new and powerful experience, as they often felt dismissed when attempting to speak about their trauma experiences in the past. Most participants were surprised by how meaningful and unexpected it was to receive acknowledgment from strangers. These findings corroborate other studies that have shown that acknowledging one's own pain and speaking about it in the company of a trusted witness can break the silence around trauma, thus ushering in the opportunity for new beginnings (Gobodo-Madikizela, 2003).

Such an experience feels liberating for the victim as he or she begins to gain mastery over traumatic memory and is therefore able to begin to release pain associated with the past (Gobodo-Madikizela, 2003; Straker, 1999).

A second theme highlighted the intimacy that was created within the group during mutual witnessing. A few participants spoke about the “disconnection” they had felt at the beginning of the workshop, and how they had then noticed that it had shifted and diminished during the storytelling process when emotional connections were formed. In Herman’s (1997) model of trauma and recovery, this shift from disconnection to intimacy marks the end of the mourning phase and the beginning of reconnection, which is the final stage of recovery wherein one has come to terms with one’s trauma. In this process, the victim is able to reconnect with his- or her-self and begin to actively engage with others and develop new relationships. Based on the findings of the present study, witnessing is, indeed, a crucial component of the workshop model, facilitating a transition between Herman’s second stage and the final stage of recovery and healing, wherein participants become reconnected with themselves, their communities, and greater humanity (Diller, 2011; Herman, 1997).

The final theme in this category, *humanization of the other*, is a common theme in previous studies. Father Lapsley (as cited in Kayser, 2000, p. 18) emphasized the importance of “finding a common humanity in each other.” Kayser (2000) similarly noted how experiencing a compassionate response helped victims of the apartheid system to restore their belief in the humanity of others whom they had previously regarded as “the enemy.” In the current study, it appears that, through the process of mutual witnessing, participants can begin to develop the capacity for empathy and forgiveness.

Gobodo-Madikizela (2010) emphasized that, through the process of giving testimony, perpetrators felt remorse and became themselves rehumanized because they were able to see their victims as human rather than as soulless objects. Similarly many of the individuals Kayser (2000) interviewed had come to their own conclusion that “common humanity” had the capacity to transcend hatred and stereotypes. In the present study some participants admitted to holding stereotypes about other group members prior to hearing their stories. Witnessing the vulnerability of others through their storytelling led these participants to also question their own assumptions about others based solely on their skin color, dress, or media portrayal. Such findings suggest that awareness of a shared common humanity can promote empathy and consideration of others’ circumstances as opposed to routinely making unsupported assumptions or judgments.

Category F: Impact of the Healing of Memories Workshop

The six themes identified in this category reflect the participants’ beliefs about which aspects of the workshop were fundamental to their healing experience. The first theme in this category, *release of negative emotions*, is related to the subsequent themes identified: *creating perspective*, *reconnection*, and *appreciation for the experiences of others*. Therefore, these four themes will be grouped and discussed in conjunction with one another.

Previous research has shown the HOM workshop to be a cathartic and healing experience (Kayser, 2000; Niuodusenga & Karakashian, 2009). An important question raised by the present researcher was which components of the HOM workshop model would best facilitate healing with subclinical populations. Based on the interview data, it can be concluded that healing resulted from the combined impact of: the creation of

perspective about one's story, the restoration of the one's connection to others, and the empathy that is fostered through the process of mutual witnessing.

Sharing one's story with a receptive audience and finding similarities in the stories of others proved to be highly effective and validating for participants. That is, speaking about one's traumatic experiences out loud was both cathartic and generated perspective. Experiences that had previously been silenced were finally released, then transformed, and as a result, ceased to be a burden. This finding highlights the importance of perspective, which allows individuals to see their stories within a larger context, no longer simply specific to them or pathological (Cienfuegos & Monelli, 1983; Morgan, 2000).

Restoring connections, the third theme in this category, was widely endorsed by the participants who viewed it as fundamental to their workshop experience. In her model of trauma and recovery, Herman (1997) also considered this stage to be crucial to the healing process. As previously mentioned, one of the most devastating consequences of trauma is the impact that it has on one's relationships (Curnow, 2007; Herman, 1997; Schottenbauer, Glass, Arnkoff, & Gray, 2008). Okey, McWhirter, and Delaney (2000) found that individuals with PTSD or trauma-related symptoms present regularly with interpersonal difficulties, which were primarily marked by weakened relationships and a tendency to withdraw from others. In the current workshop, participants reported having had experiences of intimacy and trust which in turn helped them to forgive and ultimately reconnect with the others in the group and beyond.

For many of the participants, forming such connections facilitated what Franz Alexander referred to as a "corrective emotional experience." This is also a necessary

step in the healing process, which follows cathartic release, and acts to re-establish trust (Alexander & French, 1946, as cited in Hartman & Zimmeroff, 2004). For example, during the workshop, one participant formed a meaningful connection with another participant of a different race and gender, both attributes by which the former had historically felt marginalized.

Appreciation for the experiences of others, or empathy, and its role in facilitating the healing process represented another important emergent theme. All participants reported that bearing witness to others' stories greatly impacted their empathy. In her study of the HOM workshop Nathan (2009) also found that participation in HOM workshops enhanced the participants' capacity for empathy and forgiveness. In fact, lacking the capacity to empathize with the experiences of others seems to impede ones' ability to establish meaningful connections and relationships. Without meaningful relationships, victims are prone to become perpetrators, themselves, thereby reinforcing and perpetuating the cycle of trauma (Minow, 1998; Staub, 2006). This finding highlights the importance for HOM workshops of creating conditions for and facilitating interactions that will foster empathy, as it proves to be a significant and vital step in the healing process.

The fifth theme in this category, *subtle shifts*, is related to the first theme, *release of negative emotions*. *Subtle shifts* refers to the participants' sentiments about the nature of the change they experienced within the context of the workshop. In many cases participants were unable to describe their experience in words and resorted to using more visceral phrases such as "less heavy," "more centered," "lighter," and "more solid." This is noteworthy in that traumatic experiences often get stored within one's body as a result

of dissociated and fragmented memories and experiences (Herman, 1997; Levine, 1997). Particularly for individuals who have experienced trans-generational trauma, it may be especially difficult to pinpoint the source of one's discomfort or suffering.

This study did not implement any pretest or posttest measures to assess the degree of PTSD or trauma-related symptomatology experienced by participants. However, this researcher was interested in exploring the HOM as a possible intervention for those who suffer from subclinical trauma, that is, traumatic experience that does not reach the formal criteria for a diagnosis of PTSD. Perhaps, the physical and emotional descriptions of change reported by participants in the present study can be taken as reflective of the process of healing that might occur with subclinical populations, that is with individuals who are not consciously aware of their suffering or the discomfort that they tolerate in their daily lives.

The final theme generated in this category, *curiosity about the workshop in other contexts*, is not related to any of the other emergent themes found in this study since it does not directly correlate to the impact of the HOM or the healing process. Nonetheless, two participants were interested in how the workshop could be adapted or implemented with other populations, specifically those who present with greater symptomatology or who reside in geographic areas undergoing significant conflict. This curiosity, in part, may be related to the fact that nearly all of the participants were psychology graduate students who work in clinical settings with traumatized populations. Their interest raises the question about how HOM workshops might be adapted to work with different therapist and provider groups, including mental health professionals, who are frequently confronted with their clients' traumatic experiences. Those therapists who work with

trauma victims sometimes unconsciously take on physical, emotional, and cognitive symptoms similar to those of their clients or are triggered by the experiences of their clients. They may also experience significant changes in their own relationships (McCann & Pearlman, 1990). According to McCann and Pearlman (1990), whether these changes negatively impact the therapist or the therapeutic process depends upon the extent to which the therapist is able to successfully integrate, process, and transform his or her client's trauma material. In a recent study investigating the impact of vicarious traumatization, Harrison and Westwood (2009) found empathy to be a protective factor that could potentially mitigate the risk that trauma would transfer to the clinician. To this end, researchers might explore whether HOM workshops could be used to foster empathy in mental health workers and address the traumatic stress that can be transmitted from patient to therapist.

In summary, then, the power of the HOM model is somewhat dependent upon creating conditions that generate perspective, reestablish connections, facilitate witnessing, and create empathy. At the same time, many of the themes in this category seem to have a healing potential on their own, and are also interrelated.

Category G: General Thoughts

This category includes three themes that reflect the participants' general sentiments about the workshop. The first theme in this category, *simple and accessible*, captures the participants' impressions of the HOM model in general and its structure. Several participants appreciated the fact that the workshop was short-term, had simple interventions, and was therefore more accessible to a wider range of individuals, including those who are not interested in traditional one-on-one therapy approaches. Due

to its simple and integrative approach, these findings suggest that interventions such as the HOM may appeal to individuals who suffer from traumatic experiences and yet have been reluctant to seek treatment. Since trauma is widespread and the HOM model is short-term and less expensive than ongoing one-on-one therapies, the question is raised as to whether the HOM model can serve greater numbers of people more quickly and effectively.

The second theme reflected the participants' sentiments about the workshop being offered at their graduate school. For many, this conveyed the message that their school values such interventions and supports the students in attending such extra curricular activities. The embedded message within this theme is that the setting of the workshop is important, and workshop organizers should therefore carefully consider the impact of the workshop setting on the participants.

Although all participants reported having a positive experience, nonetheless, an interesting issue must be raised about the impact and influence of holding such a workshop for students at the academic institution which they attend, especially since the workshop encourages an emotional rather than an intellectual experience (Institute for Healing of Memories, 2010b). Therefore, it is possible that workshops conducted with students in school settings, where intellectualization is primary, might unintentionally alter the participant's ability to have a deeper emotional experience.

The final theme in this category reflects the participants' positive experience of the HOM workshop. None of the participants reported having had adverse reactions to their experience in the workshop. They unanimously agreed that they would recommend the workshop to others. Participants in other studies of the HOM workshop have also

reported highly positive outcomes. However, several evaluation studies of the Truth and Reconciliation Commission (TRC) in South Africa (the original inspiration for the creation of the HOM workshop), reported a retraumatizing effect as a result of witnesses telling their stories publicly (Skinner, 2000). The TRC has been widely criticized for the lack of follow-up, mental health services available to help the witness cope with the feelings that surfaced during the testimony process (Hayes, 1998; Skinner, 2000).

Several participants in this study expressed a desire for a reunion or an additional post-workshop meeting. Some of the participants exchanged contact information in order to continue the relationships they had forged during the workshop process. Others expressed a desire to have a more formal follow-up gathering as a means of staying connected to other group members or the HOM community. Several participants expressed a strong interest in pursuing a role as facilitator of future HOM workshops.

Clinical Implications of Findings

Four themes stand out as having clinical significance in the current study. First, a number of participants were motivated to attend the workshop because they felt that “something was missing from,” and they wanted an adjunct or alternative to their present, individual one-on-one therapies. Yet, despite the existence of other available group treatments, it is noteworthy that most of the participants chose to seek out individual one-on-one therapies as opposed to other forms of group treatment. This choice seems reflective of the messages embedded in western culture that emphasizes individuality. As has been discussed in the literature, a major sequelae of trauma is isolation. Based on this finding, one has to question whether society’s beliefs about physical or mental dysfunction and proper treatment might, in fact, be promoting the victims’ isolation and

the continuation of suffering by leaning more toward individuality as opposed to group therapy options. This finding suggests that there is a need in our society for collective trauma treatment models and a wider range of techniques and interventions to facilitate connections and healing in ways that individual models of treatment cannot provide.

A second crucial research finding was the central role that expressive arts, rituals, and narrative approaches (e.g., storytelling) played in the healing process. Several themes and subthemes identified in this study suggest that these nonverbal and tactile interventions helped deepen the participants' emotional experience and understanding of their own traumatic experiences. These findings challenge the notion put forth in our culture that individual one-on-one talk therapies are sufficient in the treatment of trauma-related suffering. The question that is raised here is whether talk therapies without other forms of intervention encourage intellectualization of one's experience rather than the promotion of a deeper emotional understanding that some believe is necessary in the healing process. It, therefore, follows that mental health practitioners working with trauma clients should carefully consider their approach to treatment and whether incorporating a broader range of techniques and interventions might be beneficial.

While speaking one's story out loud can be therapeutic, findings from this study, along with examples in the literature, emphasize the importance of the group and the vital role that mutual and reciprocal witnessing plays in the healing process (Herman, 1997). Findings from this study suggest that witnessing creates conditions that promote validation, empathy, and reconnection. While one-on-one therapies also provide validation, empathy, and reconnection, they do so within the intimacy of a two-way

partnership. At the end of an individual therapy session, the clients must return to their larger communities where they may not have such support. It follows, then, that the reestablishment of social bonds and connections is a final and necessary step in the healing process (Herman, 1997). Without this final step, one might feel—as expressed by participants in this study—“stuck” and unable to move forward with their lives.

Lastly, one of this researcher’s main goals was to evaluate the HOM as a collective intervention in the treatment of individuals with subclinical trauma symptoms. The research data suggests that the participants felt a sense of relief and healing as a result of the HOM workshop. While these changes were described by participants as “subtle,” they seemed to meet many of the participants expectations about what they hoped to gain from the workshop, that is, some palpable change, that would help them move forward in their lives. Traumatic events are common in today’s world (Breslau, Kessler, Chilcoat, Schultz, Davis, & Andreski, 1998; Solomon & Davidson, 1997). As such, a major assumption of this study was that the majority of study participants would have been exposed to or experienced some form of trauma at some point in their lives. It was also speculated, as the majority of the participants were high-functioning doctoral students, that they would have subclinical trauma symptomatology rather than a formal PTSD diagnosis. However, this study did not assess the participants’ degree of symptomatology prior to and following participation in the workshop. Therefore, participants’ self-report was the only measure used to assess the healing nature of the workshop. Future researchers might choose to more thoroughly assess participants’ degree of symptomatology pre- and post-workshop in order to more directly address this issue.

Limitations of the Study

The sample. While interviews provided this researcher with extensive data, a sample size of 11 participants is still rather small. Although informative, the results in this study must be viewed cautiously and should not be generalized to a larger population. Study participants were members of a unique community of graduate students who resided in the San Francisco Bay Area. Therefore, the study results cannot be generalized to other populations in different geographic regions. Further, this study failed to collect demographic and background information on participants. Factors such as educational level, age, class, and ethnicity should be carefully considered before generalizing a study's findings. As such, more research needs to be conducted with diverse populations before any solid conclusions can be drawn.

Study method. The interviews used in this study were exclusively self-report measures, and therefore, the potential for bias is great. Although the study aimed to understand the participants' subjective experiences in a HOM workshop, the mere subjectivity of the data makes it questionable. Research that uses objective measures is recommended to draw more conclusive inferences about the impact of HOM workshops.

The researcher's own subjectivity should also be taken into account along with the fact that the researcher also participated in the same HOM workshop along with the participants in this study. Having participated in an HOM workshop, it is possible that the researcher used personal feelings and experience to inform the questions that were asked of the participants. As such, the researcher may have unintentionally influenced the direction of the interviews. Similarly, it is possible that the researcher's questions demonstrated an interest in certain experiences over others, which may have prevented or

limited certain responses. For these reasons, the content analysis method was chosen to mitigate the influence of the researcher's own subjectivity. However, issues with subjectivity also arise in the coding and categorization processes. Weber (1990) addressed the dilemma unique to content analysis researchers. The method is often criticized for such issues as well as its subjectivity; yet, it also allows one to draw inferences from the data that could not be made otherwise.

Suggestions for Future Research

There is no lack of empirical research in trauma-related literature regarding interventions and treatment approaches. Both individual and collective trauma treatments have been demonstrated to significantly reduce trauma symptoms in victims with PTSD diagnoses (Kiser, Baumgardner, & Dorado, 2010; Macy, Behar, Paulson, Delman, Schmid, & Smith, 2004; Nicholl & Thompson, 2004; Van Etten & Taylor, 1998). However, what is less understood is how collective treatments compare with other treatment modalities and especially individual and one-to-one approaches, and whether such collective therapies are effective in helping subclinical victims of traumatic experience cope and move forward in their lives. There are even fewer studies that examine the healing potential of the HOM workshop model and the participants' experiences within these workshops. For these reasons, a potential list of future studies could be extensive. What follows is an overview of several directions for future study of the HOM workshop based on the results of this current study.

The current research identified several components of the HOM workshop model that participants found central to their healing process, and this provided support for the idea that collective interventions facilitate catharsis and relief from a victim's

symptomatology. The term “healing,” however, was loosely defined in the current study, and the degree of the participants’ trauma-related symptoms was not assessed at any point during the workshop process. It is, therefore, important for future research in this area to collect more thorough background and demographic information on participants and assess their degree of trauma-related symptomatology throughout the workshop process. These demographic data may enable one to more accurately measure healing as well as the workshop’s utility in helping its participants cope with varying degrees of suffering.

Future research should also focus on educating potential participants and mental health professionals about the availability of group treatments, including workshops like the HOM. Most study participants heard about this workshop through a presentation that was given at their school. Without this presentation, it is unlikely that they would have agreed to participate in this study. Because trauma is widespread and its symptoms are often untreated, it is essential that future research explores how to more widely market and make available collective trauma treatment methodologies with demonstrable healing outcomes such as the HOM model that was the focus of the present study.

Finally, there appears to be a split between individual one-on-one therapeutic interventions and collective group treatment approaches. In this researcher’s experience working in community clinic settings, many clients participate in either one-on-one treatment or group treatment, but rarely both at the same time. The theme regarding the HOM as a potential adjunct to one’s individual treatment raises an interesting question. Previous studies have demonstrated the efficacy of both individual and group therapies for the treatment of trauma. However, future research that examines the impact of a

combined treatment could illuminate different ways of marketing and implementing the HOM workshop model. Findings from this study also suggest that it would be useful to educate therapists with traumatized clients about the benefits of collective interventions, the therapeutic use of expressive arts, and the role of rituals to facilitate healing. It is important to keep in mind, however, that individual responses to trauma are unique, and therefore, one's approach to treating trauma should also be individualized. Hopefully, continued research on the HOM model and its benefits will encourage clinicians to consider implementing more collective and integrative interventions into their practices.

Conclusion

Identifying useful interventions for trauma treatment and healing is crucial given the continued rise of interpersonal violence, global conflict, and uncontrollable natural disasters. In order to fully appreciate the prevalence of trauma and its damaging effects, first responders, trauma workers, psychologists, and government officials—indeed, everyone involved—need to continue to work together toward increasing victims' access to interventions that promote healing, especially those that are collective in nature and less familiar to the ordinary practitioner such as the HOM workshop that was the object of study in the present analysis.

This study is a continuation of other researchers' efforts to fully understand the unique experiences of trauma victims and to examine the healing potential of HOM workshops with populations whose symptoms may go unrecognized and unaddressed. It is clear from the limited number of studies on this topic that much more attention to this area of research is needed to better understand the potential of these workshops to lead trauma victims on a journey towards healing.

While reflecting about my decision to enroll in the HOM workshop, I recognized how personal my reasons were. I have been fortunate enough to have lived my life thus far surrounded by people who love me, care for me, and help keep me safe. I have also been struck, on occasion, by a profound and deep sense of sadness and fear that I could not make sense of. I also had a feeling that something was constantly holding me back. My conscious choice to enroll in the HOM workshop had to do with my interest, as a therapist in training, in trauma treatment as a means to help my clients. In retrospect, however, I believe I was also unconsciously motivated to attend the workshop to reconcile some of my own family's complex history and begin my own healing process. Through the development of my own narrative, I found I was able to make sense of my ancestors' traumas and incorporate their experiences into my own life story.

I feel honored and grateful that many of the participants in this study trusted me enough to open up and share their stories with me during the interview process. Throughout this interview process, I not only studied the participants' experiences in the workshop and the ways in which they had benefitted from it, but I also learned more about them as individuals and was able to connect with them on a deeper level. As a result, I was able to process my own experience in the workshop in a profound way and gain greater clarity about the personal shifts that I made in the process.

I close with the words of one participant who so eloquently summarized the power of the HOM workshop experience:

In the process of telling your story and hearing other people's stories, one is reminded of a shared humanity and the sense of community that comes with that.... In sharing and hearing other people's stories, there is this greater profound sense of connection and what it means to be with other humans ... Who they are, what they mean, and how we can reach out to each other.

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APPENDICES

Appendix A

Dear Participants:

I hope this e-mail finds you well and in a good place personally. On behalf of the facilitators I would like to thank you for all of your hard work and openness in making our workshop together a most positive experience. We are currently exploring the next step in our evolution as an organization that hopes in the future to be able to share our workshops and basic approach with a variety of populations and settings in the greater Bay Area.

I am writing you for two additional reasons. First, I would like to again inquire, once the dust has settled a bit, which of you continue to be interested in training to be facilitators and perhaps eventually joining our team of professionals. If you are interested, please send me an e-mail to that effect, and I will keep you informed about our various efforts and offerings as well as trainings in facilitation. We are hoping to be able to offer workshops and facilitator trainings for students on a yearly basis.

Second, Laura Tabak, who was one of the participants in our workshop, has decided to study the Healing of Memories Workshop as the subject of her dissertation research. I will be serving as the Chair of her dissertation committee. She will be carrying out a qualitative study of the Healing of Memories process and would like to interview those of you who are willing about your experience as participants in our recent workshop. Confidentiality and all human subjects requirements will be in effect. Interviews will last between one and one and a half hours approximately and will be tape recorded for transcription, and you will be made aware of the results when the research has been completed. Laura hopes to carry out the interviews during late June and July, and will be at your convenience as far as time and place. If you would be willing to serve as a subject in her research and be interviewed about your experience in the workshop, please let me know via e-mail, so we can put together a list of possible subjects. Laura's research will be the first comprehensive psychological and empirical study of the HOM process per se that I am aware of.

Warm regards,

Jerry Diller

Appendix B

Dear Participant,

Spring 2010

My name is Laura Tabak, and I am a doctoral student in clinical psychology at the Wright Institute in Berkeley, California. I am conducting my dissertation research on the experience of participating in a Healing of Memories workshop. Your participation would assist in the completion of the study. If you choose to participate, your participation would involve an hour-long semi-structured interview in which you will be asked questions related to your experience as a participant in the workshop that took place April 30-May 2, 2010. In considering participation please consider the following:

1. Participation involves minimal risk to you beyond the possibility of some mild anxiety in considering and responding to the topic and questions.
2. Participation results in no direct benefits to you beyond what might be gained by the experience of participating in a research study, and contributing to a better understanding of the topic.
3. Confidentiality will be protected to the full extent of the law. No identifying information is required to participate in the study.
4. If you have any questions or problems as a result of participating in the study you may contact Laura Tabak at 415.246.6880 or by email at HOMstudy2011@gmail.com. You are also welcome to contact my dissertation Chair, Jerry Diller, Ph.D. at 510.847.3389.
5. Your participation is completely voluntary. Refusal to participate involves no penalty or loss of benefits and you may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. You may also refuse to answer any question.
6. You may receive further information regarding the purpose and/or results of the study following participation by contacting the researcher, Laura Tabak, M.A. at 415.246.6880 or by email at HOMstudy2011@gmail.com.

I appreciate your considering participation in the study and welcome any questions, comments or suggestions that you may have concerning your participation in the study. Thank you very much for your time.

Sincerely,

Laura Tabak, M.A.

Appendix C

Informed Consent Form

I, _____ hereby authorize Laura Tabak to gather information from me for a study being conducted in association with the Wright Institute in Berkeley, California. The nature of the study and my participation in it has been explained to me and I understand the following:

1. The study is a study of participants' experience in a Healing of Memories workshop and my participation will involve responding to a series of questions in an hour-long semi-structured interview.
2. My participation will involve minimal risk to me beyond the possibility of some mild anxiety in considering and responding to the topic, questions, and / or materials.
3. My participation results in no direct benefits to me beyond what might be gained by the experience of participating in a research study, and contributing to a better understanding of the topic.
4. My confidentiality will be protected to the full extent of the law. My identifying information will be removed from my materials by the researchers as soon as they are received and stored by the researcher in a separate secure location. With the exception of the signed Consent Form, that legally must be stored in the confidential files of the Wright Institute Committee for the Protection of Human Subjects, only the researcher will have access to the identifying information.
5. If I have any questions or problems as a result of participating in the study I may contact Laura Tabak at 415.246.6880 or Jerry Diller, Ph.D. at 510.847.3389.
6. My participation is voluntary and has been gained without coercion. My refusal to participate would involve no penalty or loss of benefits and I may discontinue participation at any time without penalty or loss of benefits to which I am otherwise entitled.
7. I may receive further information regarding the purpose and/or results of the study following participation by contacting the researcher, Laura Tabak at 415.246.6880.

(Participant signature)

(Date)

Appendix D

Consent to Tape Record

I, _____, authorize the tape recording of my interview for the purpose of this study. I understand that these recordings will be reviewed by the primary investigator and will be used only for the purpose of analyzing and coding data. All information gathered will remain confidential and the tapes and transcripts will be destroyed one year following the completion of the study.

(Participant Signature)

(Date)

Appendix E

Interview Questions

We want to know specifically about your experience of the workshop, what you brought to the workshop and what you struggled with so that we can understand the impact of the group more fully. Since we are asking you to share about your personal experience, this might include talking about or including various parts of your story. Everything you say is confidential and won't be shared with anyone.

I. Can you tell me specifically how you decided to participate in the workshop?

- 1) How did you hear about the workshop?
- 2) What were your reasons for enrolling in the workshop?
- 3) Were there issues or problems you wanted to address?
- 4) What expectations or reservations did you have prior to attending?
- 5) What parts of your life were you struggling with at the time?
- 6) Hopes? Goals? Fears?

II. Various parts of the workshop

Day 1

- 1) What do you remember about the first evening?
- 2) What, if anything, was particularly impactful for you about the first night?
- 3) What helped you to feel safe/What prevented you from feeling safe?
- 4) How did you feel with the group initially and did this change at all over time?

Day2

- 1) What do you remember about the drawing and storytelling portion of the workshop?
- 2) How was this exercise for you? Can you say a little bit about your drawing?
- 3) Had you told your story in that way before?
- 4) Did new material come up?
- 5) What was it like to have a dedicated space to talk about your life/life story?
- 6) How did you feel in the small group?
- 7) Were there people in the small group that were particularly helpful in telling your story?
- 8) Were there people in the group that you felt you identified with?
- 9) Were there people in the group who you did not identify with – and why?
- 10) What was easy/difficult about sharing?
- 11) What do you remember about the small group discussion following the storytelling?
- 12) What came up for you in this process?

Day3

- 1) What do you remember about the final day of the workshop?
- 2) Peace signs: What significance did this have for you? What was it that you wanted to leave behind?

III. Are you any different since being in the workshop?

- 1) What was the immediate effect of the workshop?
- 2) Was there a longer effect? What has happened since being in the workshop?

- 3) In what ways has the workshop changed you?
- 4) Have you thought about the workshop since?
- 5) How, if at all, were you personally affected by the group?
- 6) Do you think about your story any differently as a result of the workshop?
- 7) What kinds of issues surfaced in the process?
- 8) Where do you see yourself now on your journey?
- 9) What was your experience of doing this with others?
- 10) Have you noticed any shifts or differences in your thinking, feelings, or interactions since participating in the workshop?

IV. Is there anything else you would like to add or elaborate on about your experience?

Appendix F

Coding Structure

MOTIV

10000 MOTIVATION FOR PARTICIPATION

- 10100 Expectations/Reservations
- 10200 Reasons for enrollment
 - 10210 Issues/Problems to address
 - 10220 General interest/curiosity/other
- 10300 Miscellaneous (*seemingly unrelated material that came up when discussing decision to enroll in workshop*)

INITI

20000 INITIAL IMPRESSIONS

- 20100 Initial feelings
 - 20110 Positive feelings
 - 20120 Negative feelings/hesitation
- 20200 Safety
- 20300 Miscellaneous (*seemingly unrelated material that came up when describing initial experience of workshop*)

CREAT

30000 CREATIVE ARTS

- 30100 Drawing one's story
- 30200 Clay peace symbol
- 30300 Burning exercise
- 30400 Group celebration
- 30500 Miscellaneous (*seemingly unrelated material that came up when describing expressive arts*)

STORY

40000 STORYTELLING

- 40100 Prior experience telling one's story
- 40200 Process/experience of telling and listening
 - 40210 General/neutral comments or positive
 - 40220 Negative/Concerns/Difficulties
- 40300 Role of the group/Role of witnessing
- 40400 Dedicated space
- 40500 Safety
- 40600 Miscellaneous (*seemingly unrelated material that came up when describing experience of telling one's story*)

IMPAC

50000 IMPACT OF WORKSHOP

50100 Relational

50200 Perspective

50300 Healing/Changes/Peace

50400 Shifts in self or self-understanding

50500 Empathy and/or appreciation for others' similarities/differences/
experiences

50600 Reflection

50700 Forgiveness

50800 Miscellaneous (*seemingly unrelated material that came up during
discussion of the impact of the workshop*)

GENER

60000 GENERAL THOUGHTS ABOUT WORKSHOP/SUGGESTIONS

Appendix G

Instructions to Second Coder and Theme Reviewer

Instructions to second coder:

- 1) Review the coding structure to become familiar with individual categories.
- 2) Read each transcript carefully and thoroughly.
- 3) Using the coding structure, assign each thought, idea, or sentiment to the appropriate category by placing brackets at the beginning and the end of each statement. In the margin to the left of the brackets note, in writing, the category abbreviation and code number assignment of the statement(s).
- 4) Code all comments expressed by study participants in each transcript.
- 5) If a comment does not appear to fit within the coding structure you may
 - (a) select a category that appears to be the closest and best fit, (b) choose a category that does not appear to be a good fit but communicate this decision to other coders so that they may place similar statements into that category, or (c) discuss with the other coder the possibility of adding a new category to the coding structure.

Instructions to theme reviewer:

- 1) Review each category document where participants' statements have been sorted according to category.
- 2) When you see a sentiment expressed by two or more participants, note a brief description of this theme in the margin beside the comment and mark it with an asterisk.
- 3) Carefully read all comments placed in the miscellaneous categories to determine whether any similarities exist between subjects' sentiments that could constitute a theme. If similarities are found, please proceed to describe this theme and give it a preliminary name.