

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Homicide Survivors, Inc.: <https://homicidesurvivorsinc.org>

Homicide Survivors, Inc.'s mission is to help meet the crisis and long-term needs of families of murder victims through support, advocacy, and assistance. Their crime victim advocates are available to assist survivors throughout the process of navigating the legal system. The organization also hosts support groups for survivors to share stories, experiences, and emotions.

Office for Victims of Crime: <https://ovc.ojp.gov/topics/homicide-victims-co-survivors>

The Office for Victims of Crime is a program in the U.S. Department of Justice that supports a broad array of programs and services that focus on helping victims in the immediate aftermath of crime and continuing to support them as they rebuild their lives.

Parents of Murdered Children: <https://pomc.org>

Parents of Murdered Children (POMC) provides the emotional support to help parents and other survivors facilitate the reconstruction of life without their loved ones. POMC helps survivors deal with their grief and assists with issues in dealing with the criminal justice system. The National Headquarters of POMC assists any survivor and if possible, links that survivor with others in the same vicinity who have survived their loved one's murder.

American Association of Suicidology: www.suicidology.org

American Association of Suicidology addresses many aspects of suicide prevention, intervention, and survivor support. Its website has a section called "Suicide Loss Survivors" (www.suicidology.org/suicide-survivors/suicide-loss-survivors), which includes newsletter articles, personal stories, and a directory of support groups for survivors of suicide loss. There is also a section for clinicians who have lost a client and/or family member to suicide.

American Foundation for Suicide Prevention: www.afsp.org

American Foundation for Suicide Prevention provides a wide variety of services related to suicide prevention and coping with suicide. Its website has a section called "I've Lost Someone" (www.afsp.org/survivingsuicideloss), which offers information for survivors, as well as personal stories and a directory of support groups for survivors of suicide loss. AFSP provides a training program for support group facilitators and a survivor outreach program. AFSP also sponsors the International Survivors of Suicide Day, an event where the survivor community comes together for support and healing.

Parents of Suicides and Friends & Families of Suicides: www.pos-ffos.com

This website provides a public message board called Suicide Grief Support Forum, a listserv for parents, a separate listserv for others, and an online chat room for survivors of suicide loss.

The Compassionate Friends: www.compassionatefriends.org

The mission of The Compassionate Friends is to support family members when a child dies, at any age, who feel intense pain and may feel hopeless and isolated. The Compassionate Friends provides highly personal comfort, hope, and support to every family experiencing the death of a son or a daughter, a brother or a sister, or a grandchild, and helps others better assist the grieving family.

Video: *Why 'Deaths of Despair' May Be a Warning Sign for America* (2018; 10:22)
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REFERENCES

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- Andriessen, K., Rahman, B., Draper, B., Dudley, M., & Mitchell, P. (2017). Prevalence of exposure to suicide: A meta-analysis of population-based studies. *Journal of Psychiatric Research*, 88, 113-120. <https://doi.org/10.1016/j.jpsychires.2017.01.017>
- Bastomski, S., & Duane, M. (2019). *Losing a loved one to homicide: What we know about homicide co-victims from research and practice evidence*. Center for Victim Research.
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. Penguin.
- Bellini, S., Erbuto, D., Andriessen, K., Milelli, M., Innamorati, M., Lester, D., Sampogna, G., Fiorillo, A., & Pompili, M. (2018). Depression, hopelessness, and complicated grief in survivors of suicide. *Frontiers in Psychology*, 9, 198. <https://doi.org/10.3389/fpsyg.2018.00198>
- Berman, A. (2011). Estimating the population of survivors of suicide: Seeking an evidence base. *Suicide and Life-Threatening Behavior*, 41, 110-116. <https://doi.org/10.1111/j.1943-278X.2010.00009.x>
- Bolton, J. M., Spiwak, R., & Sareen, J. (2017). Consequences of sibling death: Problematic, potentially predictable, and poorly managed. *JAMA Pediatrics*, 171(6), 519-520. <https://doi.org/10.1001/jamapediatrics.2017.0330>
- Bonanno, G. A., Neria, Y., Mancini, A., Coifman, K. G., Litz, B., & Insel, B. (2007). Is there more to complicated grief than depression and posttraumatic stress disorder? A test of incremental validity. *Journal of Abnormal Psychology*, 116, 342-351. <https://doi.org/10.1037/0021-843X.116.2.342>
- Bryant, R. A. (2013). Is pathological grief lasting more than 12 months grief or depression? *Current Opinions in Psychiatry*, 26(1), 41-46. <https://doi.org/10.1097/YCO.0b013e32835b2ca2>
- Case, A., & Deaton, A. (2017). *Mortality and morbidity in the 21st century*. *Brookings Papers on Economic Activity*, 2017, 397-476. <https://doi.org/10.1353/eca.2017.0005>
- Centers for Disease Control and Prevention. (2017). *Fatal injury reports, national and regional, 1981-2016*. <https://webappa.cdc.gov/sasweb/ncipc/mortrate.html>
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. Guilford Press.
- Columbia Center for Complicated Grief. (2018). *Overview of complicated grief*. <https://complicatedgrief.columbia.edu/professionals/complicated-grief-professionals/overview>
- Czeisler, M. É., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., Weaver, M. D., Robbins, R., Facer-Childs, E. R., Barger, L. K., Czeisler, C. A., Howard, M. E., & Rajaratnam, S. M. W. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic—United States, June 24-30, 2020. *Morbidity and Mortality Weekly Report*, 69, 1049-1057. <http://doi.org/10.15585/mmwr.mm6932a1>
- EMDR. (2021). *About EMDR therapy*. EMDR International Association. <https://www.emdria.org/about-emdr-therapy>
- Feigelman, B., & Feigelman, W. (2008). Surviving after suicide loss: The healing potential of suicide survivor support groups. *Illness, Crisis & Loss*, 16, 285-304. <https://doi.org/10.2190/IL.16.4.b>
- Figley, C. R. (1985). From victim to survivor: Social responsibility in the wake of catastrophe. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (pp. 398-413). Brunner/Mazel.
- Flatt, L. L. (2007). *The basics: Facilitating a suicide survivors support group*. Suicide Prevention Action Network: Washington, D.C. https://www.mirecc.va.gov/visn19/postvention/docs/Support_Group_Facilitator_Guide.pdf
- Frakt, A. (2020, December 30). *What can be learned from differing rates of suicide among groups*. The New York Times. <https://www.nytimes.com/2020/12/30/upshot/suicide-demographic-differences.html>
- Hendin, H., Lipschitz, A., Maltsberger, J. T., Haas, A. P., & Wyncoop, S. (2000). Therapists' reactions to patients' suicides. *The American Journal of Psychiatry*, 157(12), 2022-2027. <https://doi.org/10.1176/appi.ajp.157.12.2022>
- Herman, J. L. (1997). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. Basic Books.
- Janet Kuramoto, S., Brent, D. A., & Wilcox, H. C. (2009). The impact of parental suicide on child and adolescent offspring. *Suicide and Life-Threatening Behavior*, 39(2), 137-151. <https://doi.org/10.1521/suli.2009.39.2.137>
- Jamison, K. R. (1999). *Night falls fast: Understanding suicide*. Random House.
- Jordan, J. R. (2020). Lessons learned: Forty years of clinical work with suicide loss survivors. *Frontiers in Psychology*, 11, 766. <https://doi.org/10.3389/fpsyg.2020.00766>
- Jordan, J. R., & McIntosh, J. L. (2011). Is suicide bereavement different? A framework for rethinking the question. In J. R. Jordan & J. L. McIntosh (Eds.), *Grief after suicide: Understanding the consequences and caring for the survivors* (pp. 19-42). Routledge.

- caring for the survivors (pp. 19–42). Routledge.
- Keyes, K. M., Pratt, C., Galea, S., McLaughlin, K. A., Koenen, K. C., & Shear, M. K. (2014). The burden of loss: Unexpected death of a loved one and psychiatric disorders across the life course in a national study. *The American Journal of Psychiatry*, 171(8), 864–871. <https://doi.org/10.1176/appi.ajp.2014.13081132>
- Kilpatrick, D. G., & Acierno, R. (2003). Mental health needs of crime victims: Epidemiology and outcomes. *Journal of Traumatic Stress*, 16(2), 119–132. <https://doi.org/10.1023/A:1022891005388>
- Levine, P. A. (1997). *Waking the tiger: Healing trauma: The innate capacity to transform overwhelming experiences*. North Atlantic Books.
- MacGillis, A. (2021, March 8). *The lost year: What the pandemic cost teenagers*. ProPublica. <https://www.propublica.org/article/the-lost-year-what-the-pandemic-cost-teenagers>
- Meyers, L. (2015, October 19). *Facing the specter of client suicide*. Counseling Today. <https://ct.counseling.org/2015/10/facing-the-specter-of-client-suicide/>
- Milman, E., Neimeyer, R. A., Fitzpatrick, M., MacKinnon, C. J., Muis, K. R., & Cohen, S. R. (2018). Prolonged grief symptomatology following violent loss: The mediating role of meaning. *European Journal of Psychotraumatology*, 8(Suppl. 6), 1503522. <https://doi.org/10.1080/2008198.2018.1503522>
- Mitchell, A. M., & Terhorst, L. (2017). PTSD symptoms in survivors bereaved by the suicide of a significant other. *Journal of the American Psychiatric Nurses Association*, 23(1), 61–65. <https://doi.org/10.1177/1078390316673716>
- Monson, C., & Shnaider, P. (2014). *Treating PTSD with cognitive-behavioral therapies: Interventions that work*. American Psychological Association.
- Parkes, C. M. (2001). Bereavement dissected—A re-examination of the basic components influencing the reaction to loss. *Israel Journal of Psychiatry and Related Sciences*, 38, 150–156.
- Parkes, C. M. (2013). *Love and loss: The roots of grief and its complications*. Routledge.
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- Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. Norton & Co.
- Pinto, S., Soares, J., Silva, A., Curral, R., & Coelho, R. (2020). COVID-19 suicide survivors—A hidden grieving population. *Frontiers in Psychiatry* 11, 626807. <https://doi.org/10.3389/fpsyg.2020.626807>
- Reed, M. D., & Caraballo, K. (2021). Voice of the victims: Accounts of secondary victimization with the court system among homicide co-victims. *Journal of Interpersonal Violence*. Advanced online publication. <https://doi.org/10.1177/0886260521989732>
- Rosenfeld, R., Abt, T., & Lopez, E. (2021). *Pandemic, social unrest, and crime in U.S. cities*. National Commission on COVID-19 and Criminal Justice. <https://covid19.counciloncj.org/2021/01/31/impact-report-covid-19-and-crime-3/>
- Royden, L. (2019, July 30). *Sibling suicide: An avalanche on life's path*. Psychology Today. <https://www.psychologytoday.com/us/blog/the-mourning-after/201907/sibling-suicide-avalanche-lifes-path>
- Saunders, B. E. (2003). Understanding children exposed to violence: Toward an integration of overlapping fields. *Journal of Interpersonal Violence*, 18(4), 356–376. <https://doi.org/10.1177/0886260502250840>
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- Shapiro, F., & Maxfield, L. (2002). Eye Movement Desensitization and Reprocessing (EMDR): Information processing in the treatment of trauma. *Journal of Clinical Psychology*, 58(8), 933–946. <https://doi.org/10.1002/jclp.10068>
- Spungen, D. (1998). *Homicide: The hidden victims: A guide for professionals*. Sage Publications.
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- Vesper, J. H., & Cohen, L. J. (1999). Litigating posttraumatic stress disorder: Effects on the family. *The Journal of Psychiatry & Law*, 27(2), 313–337. <https://doi.org/10.1177/009318539902700204>
- Wilcox, H. C., Kuramoto, S. J., Lichtenstein, P., Långström, N., Brent, D. A., & Runeson, B. (2010). Psychiatric morbidity, violent crime, and suicide among children and adolescents exposed to parental death. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(5), 514–523.

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<https://doi.org/10.1016/j.jaac.2010.01.020>

World Health Organization. (2019). *Suicide*. <https://www.who.int/news-room/fact-sheets/detail/suicide>

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- Frakt, A. (2020, December 30). *What can be learned from differing rates of suicide among groups*. The New York Times. <https://www.nytimes.com/2020/12/30/upshot/suicide-demographic-differences.html>
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- Jamison, K. R. (1999). *Night falls fast: Understanding suicide*. Random House.
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- caring for the survivors (pp. 19–42). Routledge.
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- Kilpatrick, D. G., & Acierno, R. (2003). Mental health needs of crime victims: Epidemiology and outcomes. *Journal of Traumatic Stress*, 16(2), 119–132. <https://doi.org/10.1023/A:1022891005388>
- Levine, P. A. (1997). *Waking the tiger: Healing trauma: The innate capacity to transform overwhelming experiences*. North Atlantic Books.
- MacGillis, A. (2021, March 8). *The lost year: What the pandemic cost teenagers*. ProPublica. <https://www.propublica.org/article/the-lost-year-what-the-pandemic-cost-teenagers>
- Meyers, L. (2015, October 19). *Facing the specter of client suicide*. Counseling Today. <https://ct.counseling.org/2015/10/facing-the-specter-of-client-suicide/>
- Milman, E., Neimeyer, R. A., Fitzpatrick, M., MacKinnon, C. J., Muis, K. R., & Cohen, S. R. (2018). Prolonged grief symptomatology following violent loss: The mediating role of meaning. *European Journal of Psychotraumatology*, 8(Suppl. 6), 1503522. <https://doi.org/10.1080/2008198.2018.1503522>
- Mitchell, A. M., & Terhorst, L. (2017). PTSD symptoms in survivors bereaved by the suicide of a significant other. *Journal of the American Psychiatric Nurses Association*, 23(1), 61–65. <https://doi.org/10.1177/1078390316673716>
- Monson, C., & Shnaider, P. (2014). *Treating PTSD with cognitive-behavioral therapies: Interventions that work*. American Psychological Association.
- Parkes, C. M. (2001). Bereavement dissected—A re-examination of the basic components influencing the reaction to loss. *Israel Journal of Psychiatry and Related Sciences*, 38, 150–156.
- Parkes, C. M. (2013). *Love and loss: The roots of grief and its complications*. Routledge.
- Payne, P., Levine, P. A., & Crane-Godreau, M. A. (2015). Somatic experiencing: Using interoception and proprioception as core elements of trauma therapy. *Frontiers in Psychology*, 6, 93. <https://doi.org/10.3389/fpsyg.2015.00093>
- Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. Norton & Co.
- Pinto, S., Soares, J., Silva, A., Curral, R., & Coelho, R. (2020). COVID-19 suicide survivors—A hidden grieving population. *Frontiers in Psychiatry* 11, 626807. <https://doi.org/10.3389/fpsyg.2020.626807>
- Reed, M. D., & Caraballo, K. (2021). Voice of the victims: Accounts of secondary victimization with the court system among homicide co-victims. *Journal of Interpersonal Violence*. Advanced online publication. <https://doi.org/10.1177/0886260521989732>
- Rosenfeld, R., Abt, T., & Lopez, E. (2021). *Pandemic, social unrest, and crime in U.S. cities*. National Commission on COVID-19 and Criminal Justice. <https://covid19.counciloncj.org/2021/01/31/impact-report-covid-19-and-crime-3/>
- Royden, L. (2019, July 30). *Sibling suicide: An avalanche on life's path*. Psychology Today. <https://www.psychologytoday.com/us/blog/the-mourning-after/201907/sibling-suicide-avalanche-lifes-path>
- Saunders, B. E. (2003). Understanding children exposed to violence: Toward an integration of overlapping fields. *Journal of Interpersonal Violence*, 18(4), 356–376. <https://doi.org/10.1177/0886260502250840>
- Scupham, S., & Goss, S. P. (2020). Working with suicidal clients: Psychotherapists and allied professionals speak about their experiences. *Counselling & Psychotherapy Research*, 20(3), 525–534. <https://doi.org/10.1002/capr.12288>
- Shapiro, F., & Maxfield, L. (2002). Eye Movement Desensitization and Reprocessing (EMDR): Information processing in the treatment of trauma. *Journal of Clinical Psychology*, 58(8), 933–946. <https://doi.org/10.1002/jclp.10068>
- Spungen, D. (1998). *Homicide: The hidden victims: A guide for professionals*. Sage Publications.
- Stone, D. M., Simon, T. R., Fowler, K. A., Kegler, S. R., Keming, Y., Holland, K. M., Ivey-Stephenson, A. Z., & Crosby, A. E. (2018). Trends in state suicide rates — United States, 1999–2016 and circumstances contributing to suicide — 27 states, 2015. *Morbidity and Mortality Weekly Report*, 67(22), 617–624. <https://doi.org/10.15585/mmwr.mm6722a1>
- Turner, J. A., Finkelhor, D., & Henly, M. (2018). Exposure to family and friend homicide in a nationally representative sample of youth. *Journal of Interpersonal Violence*, 36(7–8), NP4413–NP4442. <https://doi.org/10.1177/0886260518787200>
- Vesper, J. H., & Cohen, L. J. (1999). Litigating posttraumatic stress disorder: Effects on the family. *The Journal of Psychiatry & Law*, 27(2), 313–337. <https://doi.org/10.1177/009318539902700204>
- Wilcox, H. C., Kuramoto, S. J., Lichtenstein, P., Långström, N., Brent, D. A., & Runeson, B. (2010). Psychiatric morbidity, violent crime, and suicide among children and adolescents exposed to parental death. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(5), 514–523.

SECTION III: INTOLERANCE AND THE TRAUMA OF HATE

CHAPTER 16

The Moral Psychology of Evil: A Roadmap

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CHAPTER OVERVIEW

This chapter examines the construct of evil from the perspective of moral psychology. The chapter first discusses contemporary theories of evil and common misconceptions about evil. The chapter then draws on examples from social psychology in order to examine the psychological and situational causes of evil actions. The relation between trauma and evil is then explored with an emphasis on Primo Levi's account of Auschwitz and the concept of the "gray zone." Finally, the chapter discusses the nature and possibility of healing and reconciliation ("moral repair") after evil has been done.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Understand issues related to evil from an interdisciplinary moral psychological perspective;
2. Develop awareness of contemporary theories of evil and common misconceptions about evil;
3. Distinguish between a "situationist" and "dispositionalist" explanation of evil, based on examples from social psychology;
4. Become familiar with the concept of the "gray zone" and the traumatic effects it has on its inhabitants;
5. Identify problematic areas and possibilities concerning healing and reconciliation that are associated with evil.

INTRODUCTION

Lynching was a common event in the American South during the late 19th and into the early decades of the 20th centuries. James Allen and Jon Lewis recount one ghastly case that took place in Morven, Georgia, on the 19th of May 1918:

The brutalities meted out in these years often exceeded the most vivid of imaginations. After learning of the lynching of her husband, Mary Turner—in her eighth month of pregnancy—vowed to find those responsible, swear out warrants against them, and have them punished in the courts. For making such a threat, a mob of several hundred men and women determined to "teach her a lesson." After tying her ankles together, they hung her from a tree, head downward. Dousing her clothes with gasoline, they burned them from her body. While she was still alive, someone used a knife ordinarily reserved for splitting hogs to cut open the woman's abdomen. The infant fell from her womb to the ground and cried briefly, whereupon a member of this Valdosta, Georgia, mob crushed the baby's head beneath his heel. Hundreds of bullets were then fired into Mary Turner's body, completing the work of the mob. The *Associated Press*, in its notice of the affair, observed that Mary Turner had made "unwise remarks" about the execution of her husband, "and the people, in their indignant mood, took exceptions to her remarks, as well as her attitude." (Allen & Lewis, 1999, p. 14)

remarks, as well as her attitude.” (Allen & Lewis, 1999, p. 14)

Mary Turner’s story provides a paradigmatic portrait of evil. The lynchers were not merely doing something “bad.” To call their actions bad—even *very, very* bad—would be an egregious understatement. “Evil,” however, seems like the appropriate predicate: it is a word that we reserve today for the most heinous actions, the vilest of deeds. Evil sits atop the highest rung in the hierarchy of moral wrongs. We respond to evil with revulsion, but also with incredulity. These sorts of wrongs often strike us as incomprehensible. They seem to transcend the very boundaries of sensibility. Thus, the common refrain about evil is: “How could somebody do something *like that*?” This chapter outlines some approaches to answering this question from the perspective of moral psychology. Moral psychology is an interdisciplinary enterprise. It combines the resources of psychology and philosophy in a mutually reinforcing attempt to illuminate concepts and answer questions about human behavior in morally significant contexts (Doris, 2006/2020). But moral psychology is not merely oriented toward explanatory ends. It seeks to address the ethical matters themselves that are at stake in our discussion. For instance, a moral-psychological account of evil should help us determine how (and whether) we can avoid evil and what we should do about its presence in the world. This too is an aim of this chapter.

The remainder of the chapter is split into the following sections. In the second section, I clarify the object of our investigation—the nature of evil—by outlining a contemporary theory of evil offered by the philosopher Claudia Card (2002, 2010). I also address some “myths” or misconceptions that are commonly held about evil. In the third section, I canvass some of the major axes of the debate in moral psychology between so-called “situationist” and “dispositionalist” explanations of evil by drawing on the empirical work in social psychology of Stanley Milgram, Phillip Zimbardo, and others. In the fourth section, I turn to examining a particular kind of evil—what Levi (1986/1989/2017) calls the *gray zone*—that poses serious questions about healing and reconciliation in the face of evil and its harms. I conclude with a summary of the chapter content, followed by a list of practice-based resources available online.

THEORIZING AND DEMYTHOLOGIZING EVIL

The term “evil” carries a lot of baggage, and different people place different meanings on the word itself. The construct of “evil” insinuates different nuances across various disciplines and professions. In this section, I present a philosophical theory of evil and debunk some common myths about it.

Card’s Theory

Evil—like the term “good”—is an irreducibly normative concept. It is not employed simply to describe a phenomenon, for example, an action, motive, or person. To call some phenomenon, X, “evil” is to *evaluate* X, or to *prescribe* a certain action or emotional response to X, or *recommend* a mode of comportment toward X. In Western history, the concept of evil has had a relatively broad usage; the domain of “evil” was roughly coextensive with that of the “bad.” It designated anything that could be counted as one of the “minuses” of life: everything from disease, earthquakes, and even ugliness, to malevolence, violence, and blasphemy. This is the notion that is operative in theological discussions about the “problem of evil.” Roughly, the problem deals with explaining how the existence of evil could be compatible with the existence of an omnipotent, omniscient, and omnibenevolent God (For some representative works, see Augustine’s [1960] *Confessions*; Hick’s [1966/2010] *Evil and the God of Love*; Mackie’s [1955] “Evil and Omnipotence”; and Adams’ [1999], *Horrendous Evils and the Goodness of God*). However, over the last two centuries, the concept of evil has narrowed in its scope to refer more exclusively to moral wrongdoings, or rather, to a certain subset of moral wrongdoings.

Intuitively, there is a difference between doing something wrong, say, stealing a chocolate bar from the grocery store, and doing something evil, such as setting the neighbor’s dog on fire out of mere boredom. This raises the following questions: What is the difference between

lesser wrongs and evil wrongs? What is the evil-making feature of moral wrongdoing? An applicable theory of evil is offered here, partially as an answer to these questions. There are, of course, various theories of evil that purport to answer these questions (for a useful examination of theories of evil, see [Calder's \[2013/2018\]](#) article, "The Concept of Evil" in the *Stanford Encyclopedia of Philosophy*). For the purpose of this chapter, and in light of a major topic of this textbook, trauma, I examine [Card's \(2010\)](#) influential account of evil in her book, *Confronting Evils*. I provide the essential details of her theory and offer some elaborations along the way.

[Card's \(2002\)](#) theory is known as "the atrocity paradigm." The theory is specifically tailored to account for the sense in which actions, institutions, and practices can be evil, but it is not intended as a theory of evil personhood. Card specifically seeks to avoid attributing evil to persons. Accordingly, for Card, individuals can *do* evil without *being* evil. I return to this important point later. The theory is called the "atrocity paradigm" because it takes atrocities to be paradigms or models of evil. Some examples of atrocities offered by Card include the 1937 Rape of Nanjing, the Tuskegee Experiment, the World War II (WWII) Japanese military's Unit 731, and the Cambodian Genocide. Card's idea is that we can generate an illuminating, helpful, and socially useful concept of evil by focusing on uncontroversial cases of evil and seeing which features constitute their "evilness." *This, however, does not mean that all evils are atrocities.* The sadistic cyberbullying of an innocent person is plausibly evil, but it is not necessarily an atrocity. The theory is also not meant to capture all possible notions and applications of the term "evil." In fact, it is unclear whether this is entirely possible or even desirable. Rather, it is meant to isolate and construct a concept of evil that is ethically significant and useful for secular, public, and moral discourse. The theory also does not imply that evils are especially rare or "extraordinary." Indeed, [Card \(2010, p. 17\)](#) thinks that evils are unfortunately all too common.

So, what is the theory? Card says that her theory combines the following two historically contrasting approaches to theorizing about evil:

1. **Stoicism:** evilness consists in the intention and/or motive behind the deed.
2. **Epicureanism:** evil consists in the experience of the harm that results from the deed.

The Stoic component is about agency—it is internal to the action and its doer. The Epicurean component is about the action's results or consequences. In Card's theory, an evil action is a (a) *reasonably foreseeable* (b) *intolerable harm* that is (c) *produced by inexcusable wrongdoing*. The first and third are the Stoic components, while the second is the Epicurean one. But, for an action to be evil, Card says, it needs to be comprised of all three components.

Reasonable Foreseeability. Reasonable foreseeability applies to the predictability of the results of the action (or policy). For a person's actions to count as evil, it must be the case that the agent who performs it foresees, or could have been expected to foresee, its consequences, if they had exercised due care ([Card, 2010, p. 28](#)). So, for instance, people who transported slaves across the Transatlantic Passage often did foresee that much of their "cargo"—upwards of 50%—would die as a result of the voyage ([Rediker, 2007](#)). But, even if they did not die, it would have been easily foreseeable, given the conditions in which the enslaved persons were held. Evil actions are ones that cause a reasonably foreseeable intolerable harm to others for morally inexcusable reasons.

Intolerable Harm. Intolerable harm, [Card \(2010, p. 8\)](#) says, consists in depriving "victims of basics ordinarily needed to make a life (or death) decent." The notion of intolerability is a normative one; it signifies what people *should not* have to tolerate, not what they *can* (or cannot) tolerate. Card's claim is that people should not have to tolerate anything that robs them of a minimally decent life.

Is intolerable harm a subjective matter? Not entirely, [Card \(2010\)](#) claims; although there is some variation, of course. Life might be intolerable for a person with diabetes if she is deprived of her insulin shots, but not for a nondiabetic individual. [Card \(2010, p. 104\)](#) says that "*Intolerable harm consists in gravely diminishing or destroying capacities central to the*

that intolerable harm consists in gravely diminishing or destroying capacities central to the meaning or value of an organism's life." For human beings, some examples could include:

access to non-toxic air, water, food, sleep, freedom from severe and prolonged pain or humiliation and from debilitating fear, having affective ties with others, having the ability to make choices and act on them, and having a sense of one's worth. (2010, p. 105)

These basic things are essential for a decent life, that is, a life that meets minimal standards of quality or that is simply not a bad one. Evils, then, cause intolerable harms of the sorts mentioned previously. Atrocities are paradigmatic examples of such harms. As a function of fair critique, I would add that "intolerable harm" is perhaps the weakest component of Card's theory, as it seems to be open to counterexamples. For instance, if John concocts a sadistic plan to murder Oscar, but he fails to accomplish it due to sheer incompetence or bad luck, does this mean that his actions were not evil? They did not produce intolerable harm, but they nevertheless do seem to be evil. This may be addressed by adding a counterfactual clause, according to which the action *would have* caused intolerable harm, if performed successfully.

Inexcusable Wrongdoing. Evils lack two kinds of excuses: (a) metaphysical and (b) moral. Metaphysical excuses focus on the aspects and conditions of the agent. *Nonculpable ignorance* is an example of a standard metaphysical excuse. John left a knife on the kitchen counter; Sally accidentally slips and cuts her finger on the knife. Is John responsible? "No," we would say, *if* he could not have reasonably known or foreseen such an occurrence. Sometimes, however, we can reasonably expect an agent to know better and, hence, to have acted otherwise than they did. Perhaps John did not intend to park a car illegally, but he is still getting a fine. Ignorance is not always a good excuse. Metaphysical excuses also can be offered when the person lacks certain agential capacities altogether, rather than merely lacking the relevant information. Sally's newborn vomited on a friend—is the baby's behavior excusable? She cannot control herself nor could she possibly know that such behavior is inappropriate. She cannot yet appreciate and follow nuanced social norms. The question of whether she "ought to have done otherwise" does not make much sense in such a case. To hold her responsible would simply be bizarre. Compulsion is yet another common metaphysical excuse. The kleptomaniac cannot control themselves; they steal things compulsively. It is an illness or mental condition that overrides or disrupts the capacity to exercise autonomous agency. These sorts of excuses are meant to reduce or completely revoke someone's culpability by reducing or denying their responsibility.

Moral excuses are meant to reduce someone's culpability, but without denying their responsibility or agency. In these cases, the person takes responsibility for the wrongdoing—and recognizes it as wrong—but claims to have had a good or "morally appropriate" or "morally defensible" reason for doing it (Card, 2010, p. 17). Morally defensible reasons are ones that count, morally, in favor of an action. For instance, Joan's water breaks; she is going into labor. Alex, her spouse, dangerously speeds down with her to the hospital. He knows that he is endangering others; he knows that it is morally wrong, but he says, "I had a good reason, I needed to get my wife to the hospital as soon as possible." That is a moral excuse. Card adds, importantly, that for something to count as a moral excuse, it is not enough for the agent to *think* that it is a good (moral) reason, but it actually must *be* a good (excusing) moral reason. The fact that someone thinks she is acting rightly does not mean that she really is acting rightly or that she is absolved from responsibility for the actions she has performed.

Evil actions, according to Card (2010, p. 20), lack both moral and metaphysical excuses. She writes, "When a deed is inexcusable, morally and metaphysically, the doer's culpability is unmitigated." This means that evildoers are blameworthy. Although, we should note, they are not necessarily always blameworthy to the *same degree*. We should also note that not all inexcusable wrongs are evil; however, according to Card, all evils are inexcusable wrongs. This means that the wrongdoer ought to have acted differently and that there is nothing that could get them "off the hook" for the actions they have done. (For a fascinating and influential discussion of evil and responsibility, the interested reader can see Watson [1987]. Watson argues that [some] cases of evil seem to suggest that the evildoer is so insensitive to proper

moral reasons that they may cease to be proper objects of blame altogether. Watson uses the example of Robert Harris, an especially callous murderer, to discuss the relationship between evil, responsibility, and childhood abuse.)

Demythologizing Evil

Card's (2002, 2010) theory, then, is that evil actions are reasonably foreseeable, inexcusable wrongs that produce intolerable harm. This yields a number of important and preliminary results (the list here is highly indebted to Eric Schwitzgebel's lectures for a class on evil at the University of California—Riverside):

1. Evildoers need not *intend to harm* others. An organization like NAMBLA (North American Man/Boy Love Association) might see itself as promoting good, ethical, and healthy romantic love between children and older men, but it is undeniably harmful in its aims. In other words, evildoers need not be malicious, or intend to harm someone for the sake of harming them.
2. Evildoers need not be *selfish*. It is possible for someone to participate in evils for the sake of one's family or one's country. "Crime families," for instance, often act for the sake of their organization rather than purely in their own self-interest. Likewise, many Nazis apparently saw themselves as protecting the German people and their nation against its foreign and domestic "enemies."
3. Evildoers need not be deeply *wicked* or *cruel*. In other words, they need not be acting for the sake of "evil itself." As Satan, in Milton's *Paradise Lost*, says, "evil be thou my good" (Milton, 2005, p. 108). Some evildoers are just callous. For instance, imagine that Joseph runs over Julie with his car, paralyzing her for life, simply in order to get home faster. Julie did not do anything to deserve this, she just happened to be in Joseph's way. He did not even want to make her suffer; rather, he just did not care about her at all. This is still a reasonably foreseeable and inexcusable wrong that causes intolerable harm: evil.
4. Evildoers can commit evil acts on the basis of *moral principles*. For instance, some Confederate soldiers during the Civil War may have sincerely believed that they were fighting for "states' rights," but that does not serve as a good moral excuse for promoting the institution of slavery. In other cases, someone might have a good moral aim, but choose an inexcusably immoral *means* to achieve that aim. For example, it is surely morally good to help one's child do well in school, but not by threatening physical violence to a teacher if she does not give the child an A.

The previous results can be marshalled to address some common myths about evil. First, recall the claim from the introduction that evil is "incomprehensible." This myth often is grounded in the supernatural aura of evil, or in really "extraordinary" cases of serial killers, for example. It seems impossible to imagine ourselves in the shoes of such people. We cannot—and often enough do not *want to*—imagine ourselves lynching, raping, murdering, or engaging in the cruelties and horrors that we identify as evil. But Card's (2002, 2010) theory suggests that some cases of evil are perfectly intelligible; evil is unfortunately human—all too human. People can commit evil or participate in evils out of laziness, apathy, self-interest, blind conformism, approval-seeking, or even sheer thoughtlessness. These are not incomprehensible motives or unintelligible psychological states. Arendt (1964) famously was struck by the figure of Adolph Eichmann—the high-ranking SS officer who organized transports to death camps during WWII and who was captured in Argentina and brought to trial in Israel in 1960—and his superficiality, his lack of imagination, his thoughtlessness and emptiness. Eichmann was not a monster, Arendt famously said, he was merely a boring, paper-pushing, bourgeois bureaucrat. Eichmann, in Arendt's famous phrase, is the face of the "banality of evil." The horrifying thing about Eichmann is not his extraordinariness, but rather his ordinariness. We all know an Eichmann. More frighteningly still, we might even be one ourselves.

The second myth is that people can be neatly categorized into "good" and "evil" groupings. This Manichean myth is perhaps a result of our tendency toward "us" and "them" thinking, that is, creating in-group and out-group divisions. We (in-group), of course, are "the good

ones" and they are the "evil ones." The feeling of moral superiority that this affords reassures us of the rightness of our ways and solidifies our bond with the members of our group. For instance, in 2015, ISIS filmed the gruesome execution of a captured Jordanian pilot. He was set aflame in a cage. Some in the United States have taken this barbaric act as a confirmation of the complete "backwardness" of the Middle East, and, by contrast, the moral superiority of the United States and the West. It is easy to forget, however, that until the middle of the last century, lynching was not only commonplace in the United States, but so were the burning of the bodies of lynching victims and their commemoration in postcards and other memorabilia, including collecting pieces of clothes, teeth, and bones from the charred bodies of the victims (Allen & Lewis, 1999). But, against the Manichean myth, Card's (2002, 2010) theory suggests that "perpetrator" and "victim" are not absolutes. They are idealized constructs that map imperfectly onto the real world. People are often both perpetrators and victims of evil. This is a possibility that is hard to digest; we do not want to think that anyone who can be a victim of evil also can be a perpetrator of evil. Yet if we are serious about stopping evil—rather than just protecting our egos—then this is a possibility that we should accept.

The dichotomous thinking surrounding good and evil closely relates to the assumed "extraordinariness" and rarity of evil. Card (2002, 2010) thinks that evil is not necessarily rare. This may be especially true in relation to practices that are widespread in one's community. It is hard to recognize some practice as evil if *everyone* is doing it. The neighbors are "good, respectable people" after all, so whatever they are doing cannot be evil, and would it not be terribly arrogant to assume that *I* know better than all the members of my community? The need to maintain communal ties creates a powerful tendency toward a general policy of unquestioning conformism (see Schwitzgebel's [2019] "Aiming for Moral Mediocrity" for a helpful discussion of this topic). Also, perpetrators tend to misperceive the harms that they inflict. They may diminish the gravity of the harms. For example, they may claim that it was not "*that* bad," or they may ignore victims altogether. Baumeister (1997a, 1997b), in discussions about threatened egotism and self-defeating responses, has suggested that victims, conversely, may tend to exaggerate the terribleness of the harm or the maliciousness of the perpetrator's motives. This is not to imply in any way that a victim has not been harmed, but rather, it speaks to the workings of cognitive schema and the way in which human beings, perhaps as a part of human nature, sometimes may magnify perceived danger as being "larger than life." For the purpose of the discussion at hand, this means that, if we want to identify someone as "evil," then we are more likely to exaggerate their intentional or motivational features and the degree of harm that they cause, but it also means that we are less likely to examine critically the harms that we ourselves have a part in creating. So, for instance, it is fair to assume that most meat-eaters in modern, affluent, industrialized countries are aware of the horrors suffered by animals in factory farms, yet it is not uncommon for them to doubt whether the animals feel much pain or whether their pain bears any substantive moral weight. More commonly still, meat-eaters probably rarely think much at all about the morality of modern meat production and consumption, nor do they consciously consider the typically horrific process that gave "birth" to the hamburger they are biting into. (For more on animal ethics, see Donaldson and Kymlicka [2011] and Will Kymlicka, *Zoopolis*, Singer [1975/2009], *Animal Liberation*, Norcross [2004], "Puppies, Pigs, and People," and Diamond [1978], "Eating Animals and Eating People."). Is this a reasonable mode of thought, or is it one that reflects precisely the claim that evildoers dismiss the harms inflicted on their victims or, indeed, the reality of victimhood itself?

EXPLAINING EVIL

In this section, I explicate a social psychological context for understanding and explaining evil. In the first subsection, I discuss the basic distinctions between two explanatory paradigms in psychology: situationism and dispositionalism. The second subsection offers a discussion of relevant social psychology experiments. The third subsection seeks to draw some conclusions from these experiments about which paradigm—situationism or dispositionalism—offers a better framework for explaining evil, especially in relation to ordinary agents.

ordinary agents.

Social Psychology and Character: Dispositions and Situations

Evil, as we have said, is not incomprehensible, nor is it necessarily extraordinary; but it is nevertheless a complex phenomenon that cries out for explanation. It is especially important to understand the factors that push people to commit evil actions if we are committed to preventing evil. In moral psychology, there are two major explanatory paradigms for people's behavior: dispositionalism and situationism. Dispositionalism is the commonsense view that human behavior is (often) the product of *character traits*, or the tendencies that constitute our "character" or personality.

Character traits are dispositions to feel, think, and act in certain ways. If I have some character trait, C, then I may be disposed, or I may have the tendency, to consistently act in certain ways and feel or think certain things. For instance, if I am compassionate, then I may be disposed to feel compassion and act compassionately toward others. The explanations that we offer for human behavior—in ourselves and in others—often rely on the attribution of such character traits. For example, Juan lied to me again, because he is *disloyal* or *insincere* or *selfish* or *forgetful*; or Maria helps me with my homework, because she is *kind* and *empathic* and *generous*. Character traits are assumed to have the following features:

1. **Character traits are stable:** If someone has a character trait, C, then it is very hard to lose or drastically alter that character trait;
2. **Character traits have a wide cross-situational consistency:** If someone has a character trait, C, then it determines and explains the person's behavior across a wide variety of situations, for example, if a person is compassionate, then that person predictably and consistently feels compassion upon seeing people in need of serious help—whether on the TV or in the street—and regardless of (many) situational factors;
3. **Character traits persist over time:** If someone has a character trait, C, then the person continues to have C throughout time, without major and sudden modification or alterations, for example, if a person is compassionate on Tuesday, then we can reliably expect that she will be compassionate next Tuesday as well.

Situationism challenges dispositionalism. According to situationism, character traits do not have the immense influence on our behavior as is assumed with dispositionalism. According to situationism, *minor and insubstantial situational factors have a much greater weight in determining and (hence) explaining human behavior than character traits do*. The insubstantiality of the factors is an important point. John Doris, a proponent of situationism, notes that there is nothing very controversial about the claim that *substantial* situational factors have an immense influence on action—I cannot, for instance, act courageously and save a drowning child unless there is a child who is drowning and in need of saving. So, the situationist point is a subtle one: "the problem is not that substantial situational factors have substantial effects on what people do, but that seemingly insubstantial situational factors have substantial effects on what people do" (Doris, 2002, p. 28). If the situationist is correct, then character traits—if they exist at all—do not really have the important role that we think they do in governing and explaining human behavior. Minor situational factors should not be able to offset robust, stable, cross-situational, and persistent characterological dispositions. We should note that situationism does not deny that *people can be or are (sometimes) compassionate, altruistic, cruel, and so on*. Situationism simply claims that people's prosocial (altruism) or antisocial (malice) behavior often is determined by situational factors rather than character traits (Doris, 2002, p. 35). Altruism is real, it is just not rooted in these global, stable, persistent character traits that typically are assumed to explain and determine people's actions.

The support for the situationist thesis comes from decades of empirical work in social psychology. There is a large number of experiments that demonstrate the power of minor situational factors in the determination of human action. Doris (2002, p. 35) writes that, "Situationism is motivated by a pattern of results, not by the results of any particular study." These studies taken together strongly suggest that character-based moral psychology is

These studies, taken together, strongly suggest that character-based moral psychology is fallacious on the situationist view. The same person can be courageous in one situation but cowardly in another, or compassionate in one case, but cruel in another, and so forth. The upshot of situationism is clear: the determining force is situational, not characterological. If this is true, it has enormous implications for how we should explain evil actions. To demonstrate this, we will examine a few of the most notable (and controversial) experiments in social psychology.

Social Psychology Experiments

Some of the most (in)famous experiments in social psychology have offered glimpses into the human psyche that assist in understanding the nature of evil. I offer several of the most prominent examples in this subsection.

Omission Experiments

First, [Isen and Levin \(1972\)](#) conducted a famous experiment that involved unwitting subjects finding a dime in a phone booth—which served as a mood-booster of sorts in the 1970s. The subjects, after finding the coin, witnessed a confederate dropping a pile of papers on the ground, seemingly by accident. Isen and Levin wanted to see if finding a coin would have an effect on people's willingness and motivation to help. The results were that 87% of those who found the dime decided to help. The mood boost from finding a dime seemed to have played an enormous role in determining their behavior; only 4% of those who did not find the dime decided to help. The dispositionalist assumes that one's character predicts whether someone will stop to help a stranger. But what seemed to make the difference was the situation—the coin—and *not* the person's character, unless we are ready to assume that the people who happened to find the coin also, by chance, happened to be more compassionate persons than those who did not find one.

Another famous experiment, by [Latane and Rodin \(1969\)](#), tested the effects of group size on bystanders' willingness to help. The subjects (university students) were told that they were participating in a market research study. They were given a questionnaire by a "representative," who then went behind a curtain that divided the room. The subjects then were interrupted by a loud crash and cries of pain coming from behind the curtain, implying that a serious accident has taken place. [Doris \(2002, p. 32\)](#) reports that "Seventy percent of bystanders offered help when they waited alone, compared with seven percent in the company of an unresponsive confederate." This is astounding. If people had robust character traits—like compassion—then minor situational factors, like having another person in the room with them, certainly should not make them *less* likely to offer help to someone in need. This important psychological phenomenon often is called "diffusion of responsibility" or the "bystander effect": A bystander feels less responsible for doing something, in an emergency, as the number of other bystanders increases. The feeling of responsibility is weakened, as it is "diffused" throughout the group. (For the interested reader, [Miller's \[2017\]](#) book, *The Character Gap*, provides many more examples of these kinds of experiments along with a discussion of situationism and its philosophical merits and implications.)

Milgram Experiments

The previously described experiments were about *omissions* of compassion. The participants failed to offer assistance, but they did not actively hurt anyone. They did not purposefully cause the confederate to drop their papers, for instance. This might suggest that there is room for dispositionalism about certain character traits, for example, compassionate people may be unwilling to severely harm other human beings as a result of minor situational factors, even if they are not so willing to provide active assistance in other situations. But, unfortunately, some experiments—specifically, the Milgram and the Stanford Prison experiments—suggest that even this is false. This research is much more disturbing.

Stanley Milgram, a psychologist at Yale, was interested in the Holocaust: Why did ordinary Germans agree to murder millions of innocent people? They could not *all* have been monsters. They could not *all* have been sadists. So, what is the explanation? Milgram's

monsters. They could not *all* have been sadists. So, what is the explanation? Milgram's experiments were designed to test obedience to authority—will people agree to *murder* if commanded to do so by an authority figure? The answer, for many, was yes: they are willing to murder on command. In the standard condition of the experiment, 65% of the participants agreed to deliver lethal, 450-volt shocks to a protesting "learner" situated in another room. Most participants protested, but nevertheless continued on at the insistence of the experimenter. Dispositionism, and commonsense, would have assumed that *no one* would comply with such orders, unless they are disposed toward sadism or extreme submissiveness, and so forth. Doris writes the following:

Milgram's experiments show how apparently noncoercive situational factors may induce destructive behavior despite the apparent presence of contrary evaluative and dispositional structures. Furthermore, personality research has failed to find a convincing explanation of the Milgram results that references individual differences. Accordingly, Milgram gives us reason to doubt the robustness of dispositions implicated in compassion-relevant moral behavior; his experiments are powerful evidence for situationism. (2002, p. 39)

The obedient participants were not horrible or monstrous people. Their verbal and bodily responses demonstrated their conflicted internal states. But the situation outweighed whatever character traits they supposedly had. Compliance varied enormously once Milgram introduced slight variations to the experimental scenario. For example, if the teacher had to hold the learner's hand down on a shock plate, obedience dropped dramatically. Participants also were much less likely to comply if the instructions were given by phone or delivered via tape recorder. But, then, there is also almost *100%* compliance whenever the participant could only hear frantic pounding on the wall, but not the learner's actual, agonized voice behind it. In general, the factors that seemed to matter most for rates of obedience were *proximity* to the experimenter and *distance* from the learner. Milgram's conclusion was that most of us would obey a malevolent authority figure in *some* situations, even if we are not directly *forced* to do anything by that authority figure.

One important situational phenomenon that the experiment demonstrates has come to be known as the "foot-in-the-door." The "teachers" are asked to start with a relatively mild electric shock, 15-volts, but they then are instructed to increase the voltage in incremental steps until they suddenly have reached a lethal or obviously harmful level. Once someone has agreed to take the initial step, the failure to take another step poses a challenge to the *justification* of the initial

one—if administering a 100-volt shock is wrong, then was it not wrong to have administered a 75-volt one? ... 45-volt? ... 15-volt? This “stepwise” progression of the experiment may have had an even greater influence than the authority itself.

Therefore, [Doris \(2002\)](#) claims, the empirical studies in social psychology tell a pretty consistent story: trivial situational factors have large effects on behavior. This challenges the commonsense dispositionalist view that character determines and explains people’s behavior. This is also, of course, very disturbing. Doris explains, “What the experiments ... highlight ... is the power of the situation; the majority of subjects [in Milgram’s experiments] were willing to torture another individual to what seemed the door of death without any more direct pressure than the polite insistence of the experimenter” ([Doris, 2002](#), p. 42).

The Stanford Prison Experiment

[Zimbardo \(2007\)](#), a social psychologist at Stanford University, conducted another infamous experiment in the early 1970s that aimed to investigate group dynamics in prisons. He constructed a makeshift prison in the basement of Stanford’s psychology department, where he closely could observe and monitor the interactions of the experiment’s participants. The participants—24 in all—were predominantly White, middle-class, university students, who had no known psychological disorders or abnormalities. They were divided up randomly into two equally numbered groups of guards and prisoners; there were nine prisoners (three on reserve) and nine guards (another three on reserve).

The prisoners initially were arrested at an unannounced time on a Sunday morning by actual Palo Alto police officers and taken into custody before being moved, blindfolded and handcuffed, into the experimental Stanford jail. Each prisoner was assigned a number, and the numbers were essentially their new “names.” They were *required* to address each other by their numbers only ([Zimbardo, 2007](#)). The guards and the “warden” (a research assistant) had a detailed list of 17 rules that the prisoners were required to memorize and follow. The rules restricted everything from food access and bathroom use to speech and body movement. For instance, rule 14 states that “All prisoners in each cell will stand whenever the warden, the prison superintendent, or any other visitors arrive on the premises. Prisoners will wait on orders to be seated or to resume activities” ([Zimbardo, 2007](#), p. 44). Notably, the prisoners also were subject to punishment for any rule violation, and some guards showed rather sadistic creativity with the punishments that they imposed and in their general rule-enforcement tactics as they slipped further into their roles—for example, throwing them in the “Hole,” demanding the prisoners “sing” their numbers during roll call, or forcing them to do pushups for purposes of humiliation ([Zimbardo, 2007](#), p. 49). Although the guards were forbidden from engaging in physical torture, abuse, or harm, they were allowed to create the psychological conditions that [Zimbardo \(2007, p. 55\)](#) associated with prisons: fear, anxiety, boredom, constant surveillance, powerlessness, deindividuation, and so forth.

The experiment infamously ended very prematurely, after 6 days, following an escalation in guard brutality and prisoners’ responses. Prisoners started revolting before the third day was over; and one prisoner—8612—seemed to experience a mental breakdown and was “released” early. Prisoners were sprayed with a fire extinguisher, forced to defecate and urinate in buckets, and had their mattresses and even clothes taken away. The experience of losing their freedom and autonomy so suddenly and dramatically, being reduced to mere numbers, and being subjected to psychological abuse and humiliation caused visible distress, depression, and anxiety in the prisoners. The guards also used various mechanisms to disrupt solidarity among the prisoners, for example, when prisoner 416 went on a hunger strike, the others were deprived of blankets and were instructed to insult “416” ([Zimbardo, 2007](#)).

In a few days, as Zimbardo says, “the boundaries between reality and simulation have seemed to erode completely” ([Zimbardo, 2007](#), p. 142). The guards acted as if they really were guards, and the prisoners answered exclusively to their numbers rather than their names. [Zimbardo’s \(2007, p. 142\)](#) explanation is that, “Role playing has become role internalization: the actors have assumed the characters and identities of their fictional roles.” Inhabiting the role of a “guard” allowed the individuals themselves to distance themselves

imaging the role of a guard allowed the individuals themselves to distance themselves from their actions: "it is not *me*, it is just the part I am *playing*." In addition, this also may represent a need to fulfill the type of aggressive and hypermasculine demands or descriptions that usually are associated with being a "correctional officer." This might further disincline the guards from recognizing or caring about the suffering of the inmates, as "that's what women do, and you're not supposed to be soft with criminals anyway." It is no wonder, indeed, that homophobic slurs and sexual humiliation made an appearance in the guard's control tactics (Zimbardo, 2007, pp. 119–120). To be sure, not all of the guards were sadistic, but none of the guards made any substantive effort to intervene with or to stop the sadistic ones. Finally, the experiment's creation of two (artificially) antagonistic groups probably further cemented the pressures that the participants may have felt to identify with and endorse the behavior of their own group members over those of the other. The Stanford Prison Experiment thus seems to confirm the situationist claim—the situational factors seemed to overpower whatever dispositional inclinations even the participants themselves assumed they had. As one of the guards reported, "I was actually beginning to feel like a guard and had really thought I was incapable of this kind of behavior. I was surprised—no, I was dismayed—to find out that I could really be a—uh—that I could act in a manner so absolutely unaccustomed to anything I would really dream of doing" (Zimbardo, 2007, p. 158).

Evil Situations and Ordinary Agents

The commonsense assumption, as we have noted, is that evil actions are explainable in terms of evil dispositions—or that evil actions are done by evil *people*. The Southerners who lynched Mary Turner, for instance, did something evil because they were evil. But the work of Zimbardo, Milgram, and other social psychologists suggests that evil-*doing* is not necessarily indicative of evil-*being*. It is entirely possible for normal, ordinary, and otherwise decent people to do evil things *if* certain situational factors are met. Although situationism emphasizes the effects of relatively minor situational factors on behavior, it is important to note (again) that more familiar and wider-scoped situational factors are of course important too. Culture, social norms, law, and language, for instance, play especially important situational roles in the production of evil. Tirrell (2012), in her "Genocidal Language Games," provides an illuminating analysis of the role that terms like "*inyenzi*" ("cockroach") played in the 1994 Rwandan genocide. "*Inyenzi*" was used as a descriptor for Tutsis; connecting them to cockroaches was not merely dehumanizing, it also licensed and motivated a certain type of response. One does not respect or reason with cockroaches, one exterminates them as the disgusting, disease-ridden, pestilential horde that they are. (Note, though, that the influence of culture and language, or indeed any situational factors, does not necessarily imply that perpetrators are not responsible for their actions.) But none of this demonstrates definitively that personality is not real or that behavioral dispositions have no predictive or explanatory power.

Staub (1989) has argued that people with certain personality types are more likely to become perpetrators, for example, those who have an "authoritarian personality." The distinguishing mark of the authoritarian personality is the "tendency to order the world and relate to people according to their position and power in hierarchies"; admiration and obedience is rendered to the superior, contempt and abuse is heaped on the inferior (Staub, 1989, p. 75). Yet even here we should remember that situational factors (such as parenting styles) have a substantial contribution. Parents who are overly punitive, who do not show affection, who emphasize "traditional" values, and who will not acknowledge "bad" emotions, like anger, sexual desire, and so on, are more likely to produce "submissiveness to authority and a tendency to devalue the powerless," that is, an authoritarian personality, in their offspring (Staub, 1989, p. 73). And "[w]hen obedience is the highest value," Staub (1989, p. 74) writes, "self-guidance becomes impossible." Therefore, both dispositional and situational factors are worth taking into consideration. For our purposes, in any case, it is sufficient to note that the practical importance of situationism is embedded in its plausible suggestion that we often are lacking in self-knowledge about the underlying drivers and determinants of our actions. Although it is fair to assume that 100% of Milgram's participants would not have

actions. Although it is fair to assume that 100% of Milgram's participants would not have believed they were capable of consensually killing a person on command, 65% of them, in fact, did consent to do so. No one would like to imagine herself capable of such acts, but if one is an ordinary person—like Milgram's participants—then one does not *know* with certainty that they are immune to the situational pressures of authority. For the situationist, the most effective strategy for avoiding evil, therefore, is avoiding situations that promote evil while creating more situations that increase altruism or promote helping behavior instead. People do worse, the situationist suggests, when they just trust that their "character" will overcome the relevant situational forces. Zimbardo's own suggestion is to create more opportunities for people to see and think of themselves as potential "heroes," or as agents who can intervene in difficult moral situations despite the counterpressures they might face. In his inversion of Arendt's famous phrase, Zimbardo (2007, p. 21) thinks that we ought to cultivate the "banality of heroism."

But are we conceding too much to the situationists when we heed their evil-avoidance advice? For instance, one might ask, what about the capacity for rational reflection and empathy? Those seem like good guides for the avoidance of evil; so, we should just cultivate empathy and promote reflexivity. Perhaps, but the importance and effectiveness of both rational reflection and empathy are surprisingly controversial subjects. Haidt (2012) has done numerous experiments demonstrating the inefficacy of moral reasoning (detailed in his book, *The Righteous Mind*). Reasoning, he claims, is used to *rationalize* an intuitive, emotional judgment that an agent has already made. In Hume's (1739/1986) famous phrase, "reason is and ought to be only the slave of the passions." Reason, on this view, cannot by itself provide moral guidance. It can only determine the best means to whatever happens to be our moral or immoral ends. Likewise, in the case of empathy, research has uncovered some uncomfortable problems. As Prinz (2011) notes, "empathy ... is easily manipulated. Evidence from jury studies suggest that jurors hand down harsher sentences when the victims are visibly emotional and lighter sentences when defendants display regret" (p. 227). More perniciously, individuals tend to empathize more with those who look like them than those who are perceived as different or alien. In a study, Xu et al. (2009) discovered that White people feel more empathy for other White people than they do for ethnically Chinese people, and the same holds the other way around. (For more on the problems with empathy, see Jesse Prinz, "Against Empathy.")

TRAUMA AND EVIL: LEVI'S GRAY ZONE

In this section, I offer a discussion of Primo Levi's concept of the "gray zone," which challenges our assumptions about evil, but, more importantly, offers some important psychological insights from the victims' perspective into the kinds of trauma and harm that evil engenders. I end with a discussion about the possibility and nature of healing and reconciliation after evil has left its mark on victims.

There is another common myth about evil that we have not had an opportunity to introduce: It is typical to assume that our moral status—as good or evil—is under our direct, personal, and complete control. Perhaps, we think, there is not much that we can do about our circumstances. We do not choose our bodies, or genes, or the environment into which we are born, but we *do* choose the basic moral orientation of our "souls." It is always possible, we think, to avoid wrongdoing, it is always possible to retain one's fundamental goodness; good and evil are not subject to *luck*. This is a myth that is closely linked with the desire to maintain the view that we are decent or good people, and to bifurcate others into the "innocent" and the "guilty," the "victim" and the "perpetrator." There is an especially strong pull to assume that one cannot simultaneously be a victim and a perpetrator. The blurring of these categories makes us especially uncomfortable. There is a simple reason for this, I suggest: Victims deserve sympathy, perpetrators deserve blame. Therefore, someone who seems to fit both categories at once "confuses our need to judge," as the Jewish-Italian author and Holocaust survivor, Levi (1986/1989/2017, p. 42), says. The dualistic Manichean narrative, which our moral concepts and judgments are tailored to fit, is incapable of recognizing, appreciating, and hence coping with moral ambiguity. The world unfortunately

recognizing, appreciating, and hence coping with moral ambiguity. The world unfortunately tends to be morally messier than our (implicit) Manicheanism demands. Levi's concept of the "gray zone," as we will see, is especially disruptive to this Manichean bifurcation between good and evil. The purpose of this section of the chapter, however, is not to dwell on the superficiality of Manicheanism. The purpose, rather, is to confront the uniquely traumatic experience of *being involuntarily placed within a deeply morally compromised position* where the line between "victim" and "perpetrator" begins to intersect and blur.

Levi's (1986/1989/2017, p. 42) final book, *The Drowned and the Saved*, is a meditation on his experiences at Auschwitz. Levi refers to Auschwitz as a "gray zone," but he does not provide a strict definition of the term. Instead, he writes, the gray zone is a place where "two camps of masters and servants both diverge and converge," thereby confusing our need for moral clarity and judgment. Card (2002), commenting on Levi, provides some helpful clarification. Gray zones, she says, have three dominant features:

1. **Victimhood:** The involuntary inhabitants of the gray zone are themselves victims;
2. **Complicity:** The inhabitants are implicated through their choices in perpetrating some of the same or similar evils on others who are already victims like themselves; and,
3. **Stress:** The inhabitants act under extraordinary and prolonged stress (Card, 2002, p. 224). I suggest adding a fourth condition, too:
4. **Systematicity:** The gray zone has been designed to promote and exploit the previously mentioned conditions among an interrelated group and for an indefinite time.

The prisoners of gray zones, as Card explains, are given positions of power over their fellow inmates (Card, 2002, p. 212). Levi describes a number of important examples of these (*Kapos* and the *Sonderkommando*) that we will examine in the text that follows. As Card notes, the inhabitants of gray zones have often already been deprived of all their worldly possessions and their loved ones before or shortly after their arrival (Card, 2002, p. 224). They may have already endured months or years of cruelty, humiliation, exploitation, degradation, poverty, hunger, and squalor. The inhabitants of gray zones therefore operate in an environment where their attachments to the world and to other people are being or have been forcibly and systematically eroded. And the only vestiges that are left of their humanity—their life and body—are themselves now under a constant and looming threat of being lost too (Card, 2002, p. 224). In this regard, it is important to note that the choices agents make within gray zones are often morally problematic, but *not* necessarily evil. Gray zones are gray precisely because of the moral ambiguity of their inhabitants, although those who *culpably create* gray zones are not themselves morally ambiguous; their actions are unquestionably evil. Gray zones often tempt victims to imagine that complicity with evil actually can be better on the whole, that is, bring about more good overall: "I cannot be of any use to anyone, if I am dead." But, according to Card (2002, p. 223), some things may yet be worse than not "being useful." It might, she suggests, be worse to becoming a tool for evil itself. Card's assumption is that *evil is the worst thing one can be or do*. This is a good reason for identifying gray zones as one of the deepest possible kinds of evils—indeed, *diabolical* evils—since gray zones threaten to destroy not just lives and bodies, but the goodness of the victims themselves. That is Satanic in the classical sense of the term: Satan as a literal corrupter of souls.

The Trauma of Gray Zones

The traumatic nature of gray zones emerges most clearly once we examine the particular effects it has on its inhabitants. Levi's (1986/1989/2017) account of Auschwitz will serve as our guide. Auschwitz is a paradigmatic but extreme case of a gray zone. The characteristic effects of the gray zone in Auschwitz, then, are meant to apply more widely to other cases, though not necessarily to the same degree or in the same way. Gray zones have four characteristic effects: (1) alienation; (2) loss of moral innocence; (3) disintegration of selfhood; and (4) survivor's shame. I discuss and explain each characteristic in what follows.

- (1) **Alienation:** Gray zones alienate their inhabitants from one another. The complicity of inhabitants threatens to *disable the possibility of solidarity* with other victims.

According to Levi, human beings have a powerful need for an “us versus them” narrative. This need is linked closely to the “Manichean myth” mentioned earlier. It is a need that leads us to reduce many social phenomena to conflicts between in-groups (“friend”) and out-groups (“enemy”). Levi claims that this is partly why spectator sports—football, basketball, and so on—are so popular. They satisfy the craving for a clean narrative that ordinary life simply cannot provide due to its moral ambiguity and complexity. The gray zone of Auschwitz of course did not satisfy the Manichean craving—Auschwitz was already incomprehensible enough, a world without “why,” as [Levi \(1958/1996\)](#) puts it elsewhere—but it went much further. According to Levi, Auschwitz outright crushed this craving at its roots:

The world into which one was precipitated was terrible, yes, but also indecipherable: it did not conform to any model; the enemy was all around but also inside. ... One entered hoping at least for the solidarity of one's companions in misfortune, but the hoped for allies, except in special cases, were not there; there were instead a thousand sealed off monads, and between them a desperate covert and continuous struggle. (1986, p. 38)

The gray zone reduces the possibility of solidarity by alienating the victims from one another. The inmates knew they were being flung into a hell, but even in hell we have an implicit and minimal expectation to be able to suffer *with* and *alongside* others. Gray zones are designed to minimize this possibility of solidarity-in-suffering by pinning inmates against themselves and giving them positions of authority over one another. The impossibility of bonding with other inmates ensured: (a) that rebellion will be less likely, and (b) that collaboration with the Nazis will be more likely. In this sense, the gray zone exhibits some distant echoes of [Marx's \(2007/1844\)](#) notion of alienated labor under capitalism, where Marx claims that workers are alienated not just from their own “species essence” and the products of their labor, but also from *one another*. Workers come to see other members of their class as competitors in the job market, for instance. If the worker does not agree to take the starvation wages offered by the owner of capital, he knows that someone else, who is even more desperate than he, will accept these wages; or some workers are offered higher-salaried positions that involve overseeing lower-tiered workers and keeping them in line (the so-called “professional managerial class”). This diminishes the possibility of solidarity between workers, thus forestalling unionization, organization, strikes, and so on, all to the benefit of the owners, of course. The “alienated labor” of the gray zone, though, is far more sinister than the Marxist version, as will soon become clear. Here is where we encounter the second important effect of the gray zone:

(2) Loss of Moral Innocence: Gray zones force their inhabitants into situations and conditions that compromise their moral integrity; our innocence is lost when the harms and wrongs that are unjustly inflicted on others are the result of choices we have made, that is, when our decisions are responsible for their suffering, even if no better course of action was available to us at the time of making these decisions. ([Card, 2002](#), p. 222)

The surest way to drive an alienating wedge between fellow victims and sufferers is to make them resent and distrust each other. Or, more preferably, to turn them into antagonistic enemies. Levi explains, first, that not everyone in Auschwitz inhabited the gray zone to an *equal degree*; and some, in his judgment, are more blameworthy than others. For instance, [Levi \(1986/1989/2017\)](#) distinguishes between lower-level functionaries and *Kapos*. The lower-level functionaries included interpreters, lice checkers, cleaners of various sorts, and so forth ([Levi, 1986/1989/2017](#), p. 44). These inmates perhaps received a slightly better ration of food or something equivalent for their complicity, but their complicity certainly did not spare them from the same kind of suffering experienced by the general or nonprivileged camp population. More importantly, this kind of complicity did not necessarily pin the victims *against* one another as enemies.

Judgment becomes much murkier, Levi says, when we examine the *Kapos* or those inmates who were given positions of authority over other inmates in exchange for certain privileges. The *Kapos* were the “managers” of labor units, barracks, and other daily tasks in camp life

that were carried out by inmates. Their role was primarily to maintain maximum efficiency, productivity, and order among the inmates. The *Kapo* system shifted the burdens of policing and organizing onto the prisoners themselves—the prisoners were to order, police, and punish each other. The *Kapos*, as Levi (1986/1989/2017), p. 46) reports, were allowed to brutalize inmates in whatever manner they like, even if doing so resulted in an inmate's death. The *Kapo* system really did, therefore, make the inmates enemies of one another.

But the most horrifying case of collaboration that Levi (1986/1989/2017) describes is surely that of the "Special Squad," the *Sonderkommando* (*SK*). The *SK* was tasked with such things as,

[maintaining] order among new arrivals ... who were to be sent to the gas chambers, to extract corpses from the chambers, to pull gold teeth from jaws, to cut women's hair, to sort and classify clothes, shoes, and the contents of the luggage, to transport the bodies to the crematoria and oversee the operation of the ovens, to extract and eliminate the ashes. (Levi, 1986/1989/2017, p. 50)

The members of the *SK* were kept apart from the general camp population, and they too were killed routinely. There was a total of 12 squads in Auschwitz's history; and, as a rule, the first assignment of each new squad was to burn the bodies of the preceding one (Levi, 1986/1989/2017, p. 50).

Levi (1986/1989/2017, p. 53) says that the creation of the *SK* was National Socialism's (i.e., the Nazis) most diabolical act. The diabolical depth of the creation of this unit consists in the attempt to offload the genocidal work—and especially the *guilt* for the genocide as such—onto the Jews themselves. In 1943, the camp was 90% to 95% Jewish, and its aim had become to fulfill the "Final Solution," or the total extermination of the Jewish people. Levi (1986/1989/2017, p. 53) sums up the second effect aptly when he writes that the *SK* "represented an attempt to shift onto others—specifically, the victims—the burden of guilt, so that they were deprived of even the solace of innocence." It is essential, however, to note that, for Levi, the *system*, not the inmates, is primarily responsible: the *fascist, totalitarian state*. The conditions under which they acted do not eliminate culpability, Levi (1986/1989/2017, p. 44) says, "but," he continues, "I know of no human tribunal to which one could delegate the judgment." It is clear, in the case of the *Sonderkommando*, that they were acting under the most extreme duress and coercion imaginable. Nevertheless, from the victims' *own* view, it is doubtful whether this exoneration matters much. There is nothing that can erase the fact of their participation in these horrors. There is nothing that can erase fully the destructive effect it has had on their self-conception. (For more on this kind of phenomenon, where an agent is not "guilty," but nevertheless feels something like as if she were so, see Williams [1981] discussion of "agent regret" in his *Moral Luck*.) This is where the third effect becomes most significant:

(3) **Disintegration of Selfhood:** Gray zones aim to annihilate the inhabitants' self-conception through a betrayal of their deepest commitments and the values that they identify with or that make them *who* they are.

The complicity in the atrocities at Auschwitz could not have happened if the victims did not have their humanity, character, self-respect—or what Levi calls their "*soul*"—reduced to nothingness. Most victims, upon arrival, had already spent years or months in an enclosed ghetto, as mentioned. They already were deprived of their rights, property, livelihood, and so on, by the Nazi regime. The Nazis euphemistically would tell them, their soon-to-be victims, that they were to be "resettled in the east" when shipping them off in crammed cattle cars to be gassed in a death camp or worked to death in a labor camp. Upon arrival, all of their leftover property was confiscated; all their body hair was shaved; they were given ragged prisoners' uniforms; their identities were reduced literally to numbers that were tattooed onto the skin of their arms. They were separated from their families, in most cases, forever. But, even here, one might think that one's character and "*soul*" can remain intact. A person's body can be destroyed, tortured, and humiliated, but the most important and central thing about a person, that which makes someone *who* they are, the values and commitments that one endorses and that constitute one's identity, one's moral decency and humanity—that we

one endorses and that constitute one's identity, one's moral decency and humanity—that, we think, cannot be “taken” from us by anyone other than ourselves.

The gray zone's aim is to eliminate this essential core of personhood. For [Levi \(1986/1989/2017\)](#), this core seems to be *moral* in its fundamental character. The same seems true for [Card \(2002, p. 217\)](#), who claims that becoming evil might be the gravest danger faced by people who endure prolonged conditions of oppression and domination. As we saw, she thinks that becoming evil might be worse than death itself. The death of the body is preferable to the death of the soul. And [Levi \(1986/1989/2017\)](#), as we will see in the text that follows, seems to echo this point too.

The disintegration of selfhood in the gray zones begins with the previously mentioned events, but it continues. Prolonged and excessive hunger, fatigue, fear, and brutality reduce the inmates to a semi-animalistic condition. These are the conditions in which people will compromise their dignity, their values, their commitments—their selfhood—for morsels of food. These are the conditions that ensure prisoners will turn on one another and, in doing so, hasten the annihilation of their own selfhood. [Wiesel \(1960\)](#), another Auschwitz survivor, relates an utterly horrific story of this sort in *Night*. He recounts how a son literally strangled his father to death over a stale piece of bread at the time of the winter death march that Auschwitz inmates were forced to endure in 1945 during the war's final days. As [Levi \(1986/1989/2017, p. 52\)](#) says, for the Nazis, “it must be shown that the Jews, the subrace, the submen, bow to any and all humiliation, even to destroying themselves.” But that is not all. Self-destruction can transcend even the disintegration of one's selfhood, the total unraveling of one's self-understanding, self-conception, or the betrayal of one's deepest values, commitments, and so on. The ultimate level of self-destruction consists in *remaking the self in the image of its oppressor*. This is perhaps clearest in the case of the SK. The SK was designed to destroy the self by making the victims resemble their Nazi oppressors ([Levi, 1986/1989/2017, p. 54](#)).

The diabolical essence of the gray zone is encapsulated in turning the victims into the mirrors of their oppressors. In the case of Auschwitz, this meant destroying the victims' souls by making them resemble the already disintegrated souls of the Nazis themselves. This theme in Levi's work is helpful for thinking about how identities are formed under oppression more generally. As many feminists, anti-colonial, and anti-racist writers have emphasized, oppressed subjectivity typically involves the internalization of the oppressor's perspective. See, for example, [Bartky's \(1990, 2002\)](#) analysis of women's subjectivity-formation under patriarchy. Patriarchal cultures formulate norms for how women “ought” to be—that is, how they ought to look, think, behave, and so on—and these norms are enshrined in “disciplinary” practices that women are expected to follow (think of dieting, makeup routines, and so on). But, as [Bartky \(2002, p. 25\)](#) writes, “The norms of feminine body discipline are not imposed upon fully formed subjects; they are importantly implicated in the very construction of our subjectivities.” Women come to internalize these norms and practices; they are incorporated into their sense of self, their identity, and they thereby come to structure their conception of their own self-worth and value—they become, for instance, “essential to her sense of herself as a sexually desiring and desirable subject” ([Bartky, 2002, p. 25](#)). Yet, in patriarchal cultures, these norms and practices essentially are tied to the satisfaction, interests, and standards of *men*. Thus, as Bartky explains, women are internalizing the perspective of men; it is not just that they come to see and understand themselves through the eyes of their oppressors; rather, they come to *identify* with their oppressors' perspective as if it were their own. The result is a kind of “psychic fragmentation” where one part of the self is used constantly to monitor, criticize, police, judge, and discipline the other. [Fanon \(1952/1986\)](#) offers a similar theory in relation to colonized subjectivity in his *Black Skin, White Masks*. Colonized peoples come to form their identities *derivatively* from their oppressors. The colonized persons internalize the racist standards of their colonizers, such that, “The colonized is elevated above his jungle status in proportion to his adoption of the mother country's cultural status” ([Fanon, 1952/1986, p. 18](#)). So, in French colonies, like Fanon's birthplace of Martinique, the person who masters the French language is considered to be more “civilized” than his “pidgin-speaking” brethren, that is, “he becomes whiter as he renounces his blackness, his jungle” ([Fanon, 1952/1986, p. 18](#)).

jungle (Fannon, 1952/1960, p. 10).

The deformation of the soul—this transformation of the oppressed into a copy of the oppressors—reveals yet another one of Levi's central themes: the moral fragility of human beings. There are very few people, Levi claims, who would have had the "moral armature" needed to resist under the conditions of the Nazi gray zone (Levi, 1986/1989/2017, p. 68). Collaboration exercises a powerful appeal. Collaborators had numerous motivations to comply. Sheer terror, fear, and prudence were, of course, typical motivators. But Levi also notes the allure of the semblance or feeling of having *any* power at all in an otherwise completely powerless and despondent situation (Levi, 1986/1989/2017, p. 43). Consider Chaim Rumkowski, for example. As Levi reports, he was the head of the Jewish Council of the Lodz Ghetto in Poland (roughly equivalent to a mayor) and a major collaborator. He tried to make his ghetto as productive as possible to the Nazis. Jewish productivity, he must have believed, would save the Jews of the ghetto from the extermination promised by the "Final Solution." In the process, however, he notoriously exploited the situation to acquire—and then abuse—the limited amount of power and authority that he actually had. He subsequently (and cynically) became known as "King Chaim" and the Lodz ghetto was eventually liquidated with almost all of its inhabitants shipped off to be gassed at Auschwitz (Rumkowski himself arriving and eventually dying there too, but by private car rather than in a crammed train). Levi (1986/1989/2017, p. 67) takes Rumkowski to be an instructive case for the morally corrupting influence that political power exerts on individuals: "At the foot of every absolute throne, men such as Rumkowski crowd in order to grab their small portion of power." Resisting the lure of power—even under the worst circumstances—is something that requires a strong moral backbone.

Similarly, Levi (1986/1989/2017, p. 56) thinks we should recognize moral fragility in the fact that "compassion and brutality" can be present in the same person at the same time. Levi recounts a story about an SS commander, Eric Mushfeldt, who seemed to feel a second of compassion for a girl who survived the gas chamber. Is this proof that, at bottom, commander Mushfeldt was a good person after all? In some sense, Mushfeldt's story can be said to demonstrate *immoral* fragility. His compassion demonstrates the fragility of his brutality, which, unfortunately, was not fragile enough. Mushfeldt had an underling finish the job the gas chamber failed to do and execute the girl with a shot of his rifle. Finally, Levi (1986/1989/2017) turns the question on his readers:

National Socialism exercises a frightful power of corruption, against which it is difficult to guard oneself. It degrades its victims and makes them similar to itself, because it needs both great and small complicities. To resist requires a truly solid moral armature. ... How would each of us behave if driven by necessity and at the same time lured by seduction? ... Like Rumkowski, we too are so dazzled by power and prestige as to forget our essential fragility. Willingly or not we come to terms with power, forgetting that we are all in the ghetto, that the ghetto is walled in, that outside the ghetto reign the lords of death, and that close by the train is waiting. (pp. 68-69)

This brings us to the final characteristic effect of gray zones:

(4) **Survivor's Shame:** The threat of disintegration of selfhood, loss of moral innocence, complicity in crimes, and the unwillingness to extend compassion or foster solidarity is conducive to producing a distinctive sense of shame in gray zone survivors (Card, 2002, p. 213).

There is a common distinction drawn between shame and guilt. People feel guilty when they have *done* something wrong, but they feel shame about who or what they *are*. The target of shame is not an action, but the self as a whole. It is true, of course, that one can be ashamed because of something one has done, but the target of the shame is not the action per se, but one's identity. I might, for instance, feel guilty about failing to call out a coworker's racist remarks, but ashamed for being a coward or failing to live up to my values. (But see Williams' [1993] *Shame and Necessity* for an account that complicates the relationship between shame and guilt.)

Gray zone survivors are apt to feel both shame and guilt as a result of the traumas from the disintegration of selfhood, loss of moral innocence, and alienation they experience in the gray

disintegration of selfhood, loss of moral innocence, and alienation they experience in the gray zone. Guilt for specific acts or omissions is likely to be persistent; but, as [Levi \(1986/1989/2017, p. 81\)](#) writes, there is also a deep and significant sense of shame in the feeling that one was not as *worthy* of surviving as one's fellows, that one is alive at the expense of someone who was a better, wiser, more virtuous human being than oneself. Indeed, the title of [Levi's \(1986/1989/2017\)](#) book, *The Drowned and the Saved*, maps precisely onto this persistent sense of survivors' shame that the "saved" are the unworthy. As [Levi \(1986/1989/2017, p. 82\)](#) claims, the "saved" were not typically those who were morally best—the kind, the compassionate, the selfless—but, rather, those who were the most egoistic and violent, those who were willing to collaborate with the enemy or trample on their fellows, those who traded their souls for a (meager) chance at prolonging their existence: "The worst survived, that is, the fittest; the best all died." [Levi's claim here sits in some tension with his remark that no court is in a position to judge survivors. Yet this also seems perfectly in line with the ambiguous nature of the gray zone. It draws our emotions in multiple and often conflicting directions; it muddies our judgment ([Levi, 1986/1989/2017, p. 42](#)). Levi's claim also perhaps overplays people's agency in gray zones. The immense role luck played in survival seems undeniable. But whichever way we interpret the claim, Levi's thought provides a strong phenomenological example of the kind of shame that survivors of atrocities are apt to experience.]

After Evil?

Evil involves intolerable harms; it can completely destroy or engulf the good in people's lives, and it can annihilate our solidarity and relationships with others precisely where they may be needed most, as, for instance, in gray zones. This raises a final question: How is it possible to cope with traumatic experiences of this sort? Some thinkers, like the psychologist Viktor Frankl, himself an Auschwitz survivor, have emphasized the need for meaning as the driving motor of human life. As [Frankl \(1959/1985\)](#) explains in *Man's Search for Meaning*, "being human always points, and is directed, to something, or someone, other than oneself—be it a meaning to fulfill or another human being to encounter" (p. 133). And he continues,

We must never forget that we may also find meaning in life even when confronted with a hopeless situation, when facing a fate that cannot be changed. For what then matters is to bear witness to the uniquely human potential at its best, which is to transform a personal tragedy into a triumph, to turn one's predicament into a human achievement. When we are no longer able to change a situation—just think of an incurable disease such as inoperable cancer—we are challenged to change ourselves. ([Frankl, 1959/1985, p. 135](#))

Frankl's approach is focused on the self as an existential subject, as a being who is, in [Sartre's \(1957\)](#) phrase, "condemned to be free," that is, a being who must take responsibility for their life and give it meaning through action (p. 23). But Frankl's approach deemphasizes the *moral* dimension of evil. Unlike cancer, evil involves moral wrongdoing. It therefore gives rise not just to the question of how *I*, as a victim, can proceed with my life, but also: What do perpetrators *owe* their victims? Is it possible to remedy or *mend* the deep forms of damage that they have done? Is *reconciliation* between evildoers and victims even possible? We close, then, with some discussion of these questions through the topic of moral repair. (For a substantive critique of Frankl's approach, please see [Lawrence Langer's \[1980\]](#) essay, "The Dilemma of Choice in the Death Camps.")

The philosopher Margaret Urban Walker understands moral repair as aiming at rebuilding or stabilizing moral relationships between wrongdoers and those they have wronged. As [Urban Walker \(2006\)](#) explains, there are three basic conditions for "making amends" or repairing relationships when wrongdoing has occurred. The wrongdoer must (1) *take responsibility* for their actions and their consequences; (2) *acknowledge* that those actions were wrong and their consequences harmful; and (3) engage in *reparative actions* (apology, for instance) that expresses the wrongdoer's will to "set right something for which amends are owed" ([Urban Walker, 2006, p. 191](#)). Yet, as [Urban Walker \(2006, p. 191\)](#) notes, it often seems like "the magnitude of injury and the disposition to take responsibility are inversely related." If Walker is right, this means that evildoers may be the least likely to take

responsibility and engage in moral repair. Urban Walker (2006, p. 195) explains that "reparative gestures, including admissions, apologies, and amends, but also excuses ... are favored where they are most likely to 'work.'" According to Walker, this regards cases in which the wrongdoer thinks they could regain social standing, mend the broken relationship, or (eventually) diminish their sense of guilt and the resentment that is directed toward them by the victim and others. So, although moral repair is *most* needed after evil, evil makes it perhaps the *least* likely to be available. Evil, in other words, poses the most significant roadblocks for the possibility of successful moral repair. Taking responsibility for evil means acknowledging and affirming shared norms that define what one has done as *inexcusably terrible*—and this introduces the possibility of a deep sense of guilt along with the acknowledgment of the aptness of resentment from the wronged party or the community. It also opens the door to costly demands for rectification by the victim(s). Taking responsibility for evil further requires evildoers to relinquish control over their narrative and to accept the authoritative role of victims (or relevant communities) in framing the events, as well as the victims' right to express their own accounts of the wrongs they have suffered and the emotions these events have wrought.

Nevertheless, moral repair after evil is not impossible. Successful moral repair requires establishing a mutual sense of *confidence* that the wrongdoer and the victim have a shared set of moral standards and values, *trust* that these standards and values will be upheld or acknowledged if they are violated, and *hope* that this trust is not misplaced and that "unacceptable treatment will not prevail" (Urban Walker, 2006, p. 210). Urban Walker (2006, p. 199) claims that successful moral repair depends ultimately on "what deep reservoirs of trust and still flowing springs of hope can be tapped." But then, what should be done in cases where evildoers fail to share the same values or norms as the victims or refuse to recognize the victim's right to hold the perpetrator(s) accountable? The victims in such cases may be completely invisible *as victims* to the perpetrators. And, what if the "reservoirs of trust and hopefulness" that are necessary for stabilizing relationships may be completely annihilated by the wrongs of the evildoers? Victims may reasonably have reservations about rebuilding confidence. This could potentially mean that evildoers would have to commit to a seemingly impossible task or a deeply morally demanding one of endless repair (Urban Walker, 2006).

In these cases, it is important to note that *communities* also may bear responsibility for moral repair rather than just perpetrators. Moral repair at the communal level has its own distinctive vicissitudes too, however. Kizuk (2020) provides an instructive example of this in her discussion of "settler shame" in the Canadian context. Kizuk has called attention to the ways in which the Canadian Truth and Reconciliation Commission, which ostensibly seeks moral repair for indigenous groups in Canada, is directed toward reaffirming the identity of settler Canadians themselves, rather than promoting justice for indigenous groups. The shame that the settler Canadians feel is directed toward their recognition that they cannot uphold their identities as "the peaceful, benevolent Canadian," but the shame itself (and its "performance") becomes a means through which their original, positive, self-identity can be restored. This is not to say that the Truth and Reconciliation Commission is wholly bad for the indigenous participants. But as Kizuk (2020, p. 7) writes, "The problem of settler shame is that it tends toward repairing the damaged self by using the indigenous other as a mute foil to enact peace upon."

Kizuk highlights some valuable lessons for communal moral repair more generally. Communities and agents who engage in reparative gestures should remain cognizant of the *power dynamics* that are already present between the parties; it is easy for those in power to frame narratives in accordance with their material, social, and psychological interests, even under the genuine guise of “justice.” And, as Kizuk (2020, p. 12) writes, “The material demands of transformative justice require a new affective attunement for settlers that is neither fleeting nor self-focused and that does not use Indigenous peoples’ pain as a canvas on which to explore our own reflexivity.”

Ultimately, the “reservoirs” of confidence, trust, and hope may never be fully restored. But morality demands that we at least do what we can for the victims; that we provide them with the proper platform to express their emotions, frame their narratives, and voice their social, political, and material demands; that we take those emotions, narratives, and demands with seriousness, compassion, respect, and love. Moral repair after evil may be an endless and difficult, perhaps in some cases even impossible, task, but it is one that morality nevertheless demands we undertake.

CONCLUSION

In this chapter, we examined evil through the lens of moral psychology. Following Card’s (2010) lead, we saw that those who *do* evil need not themselves *be* evil, and that evil can be an entirely ordinary or “banal” phenomenon. The susceptibility of ordinary agents to engage in evil was borne out by our examination of its causal determinants, specifically situational factors and personality. “Situationists” like Doris (2002) play down significantly the role of character in explaining evil behavior. Numerous experiments in social psychology, when considered together, demonstrate that even small situational factors have enormous behavioral effects, and thus, that our commonsense reliance on explaining people’s behavior via their personality (what Ross and Nisbett (1991) call the “fundamental attribution error”) may perhaps be more misleading than true. But we also noted that the approach of moral psychology is not merely concerned with *explaining* evil, it is also concerned with how we *should* respond to it, for instance, how we can avoid doing evil ourselves and what should be done after someone has been traumatized by evil. In relation to this, we discussed the trauma involved in what Primo Levi has called the “gray zone,” where victims are made complicit by their perpetrators in their own victimization as well as the victimization of others.

Repairing relationships and restoring people’s sense of trust, confidence, and hope in others and the world is, of course, a very difficult task after evil has been done. However, although it presents many obstacles and challenges, moral repair is not impossible. Because perpetrators often are unwilling to engage in moral repair, though, the responsibility often falls on communities to take up the work of moral repair in the face of evil. One hopes that, armed with a theory of evil, a proper understanding of one’s susceptibility (as an ordinary person) to doing evil, as well as an awareness of the effects that evil and gray zones can have on their victims, people—whether as part of a community or as individuals—will more readily recognize and act in ways that both reduce the prevalence of evil and remedy its life-destroying effects. In a century in which impending climate catastrophe unimaginably threatens to exacerbate every single form of oppression that already exists, an informed commitment to combatting evil could go a long way indeed.

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REFERENCES

- Adams, M. M. (1999). *Horrendous evil and the goodness of God*. Cornell University Press.
- Allen, J., & Lewis, J. (1999). *Without sanctuary: Lynching photography in America*. Twin Palms Publisher.
- Arendt, H. (1964). *Eichmann in Jerusalem: A report on the banality of evil* (2nd ed.). Penguin Books.
- Augustine. (1960). *Confessions*. Random House.
- Baumeister, R. F. (1997a). Esteem threat, self-regulatory breakdown, and emotional distress as factors in self-defeating behavior. *Review of General Psychology*, 1(2), 145–174. <https://doi.org/10.1037/1089-2680.1.2.145>
- Baumeister, R. F. (1997b). Identity, self-concept, and self-esteem: The self lost and found. In R. Hogan, J. A. Johnson, & S. R. Briggs (Eds.), *Handbook of personality psychology* (pp. 681–710). Academic Press. <https://doi.org/10.1016/B978-012134645-4/50027-5>
- Bartky, S. (1990). *Femininity and domination: Studies in the phenomenology of oppression*. Routledge.
- Bartky, S. (2002). *Sympathy and solidarity: And other essays*. Rowman & Littlefield.
- Calder, T. (2018). The concept of evil. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy*. Stanford University. <https://plato.stanford.edu/entries/concept-evil>. (Original work published 2013.)
- Card, C. (2002). *The atrocity paradigm: A theory of evil*. Oxford University Press.
- Card, C. (2010). *Confronting evils: Terrorism, torture, genocide*. Cambridge University Press.
- Diamond, C. (1978). Eating animals and eating people. *Philosophy*, 53(206), 465–479. <https://doi.org/10.1017/S0031819100026334>
- Donaldson, S., & Kymlicka, W. (2011). *Zoopolis: A political theory of animal rights*. Oxford University Press.
- Doris, J. M. (2002). *Lack of character*. Cambridge University Press.
- Doris, J. M. (2020). Moral psychology: Empirical approaches. In E. N. Zalta (Ed.), *Stanford Encyclopedia of Philosophy*. Stanford University. <https://plato.stanford.edu/entries/moral-psych-emp>. (Original work published 2006.)
- Fanon, F. (1986). *Black skin, White masks*. Translated by Charles Lam Markmann. Pluto Press. (Original work published 1952.)
- Frankl, V. (1985). *Man's search for meaning*. Washington Square Press. (Original work published 1959.)
- Haidt, J. (2012). *The righteous mind: Why good people are divided by politics and religion*. Pantheon Books.
- Hick, J. (2010). *Evil and the God of love*. Palgrave and Macmillan. (Original work published 1966.)
- Hume, D. (1986). *A treatise of human nature*. Penguin: Random House. (Original work published 1739.)
- Isen, A. M., & Levin, P. F. (1972). Effect of feeling good on helping: Cookies and kindness. *Journal of Personality and Social Psychology*, 21(3), 384–388. <https://doi.org/10.1037/h0032317>
- Kizuk, S. (2020). "Settler shame: A critique of the role of shame in settler-indigenous Relationships in Canada." *Hypatia*, 35(1), 161–177. <https://doi.org/10.1017/hyp.2019.8>
- Langer, L. L. (1980). The dilemma of choice in the death camps. *Centerpoint: A Journal of Interdisciplinary Studies*, 4(1), 53–59. [Reprinted in J. K. Roth & M. Berenbaum (Eds.), *Holocaust: Religious and philosophical implications* (pp. 222–232). Paragon House.]

- Latane, B., & Rodin, J. (1969). A lady in distress: Inhibiting effects of friends and strangers on bystander intervention. *Journal of Experimental Social Psychology*, 5(2), 189–202. [https://doi.org/10.1016/0022-1031\(69\)90046-8](https://doi.org/10.1016/0022-1031(69)90046-8)
- Levi, P. (2017). *The drowned and the saved*. Simon & Schuster. (Original work published 1986, translated 1989)
- Levi, P. (1996). *Survival in Auschwitz* (S. Woolf, Trans.). Simon & Schuster. (Original work published 1958.)
- Mackie, J. L. (1955). Evil and omnipotence. *Mind*, 64 (254), 200–212. <https://www.jstor.org/stable/2251467>
- Marx, K. (2007). *Economic and philosophic manuscripts of 1844*. Dover.
- Miller, C. B. (2017). *The character gap: How good are we?* Oxford University Press.
- Milton, J. (2005). *Paradise lost*. Oxford University Press.
- Norcross, A. (2004). Puppies, pigs, and people: Eating meat and marginal cases. *Philosophical Perspectives*, 18(1), 229–245. <https://doi.org/10.1111/j.1520-8583.2004.00027.x>
- Prinz, J. (2011). Against empathy. *The Southern Journal of Philosophy*, 49(s1), 214–233. <https://doi.org/10.1111/j.2041-6962.2011.00069.x>
- Rediker, M. (2007). *The slave ship: A human story*. Viking Adult.
- Ross, L., & Nisbett, R. E. (1991). *The person and the situation: Perspectives of social psychology*. McGraw-Hill Book Company.
- Sartre, J. P. (1957) *Existentialism and human emotions* (B. Frechtman & H. E. Barnes, Trans.). Citadel Press.
- Schwitzgebel, E. (2019). Aiming for moral mediocrity. *RES Philosophica*, 96, 347–368. <https://doi.org/10.11612/resphil.1806>
- Singer, P. (2009). *Animal liberation*. Harper Collins. (Original work published 1975.)
- Staub, E. (1989). *The roots of evil: The origins of genocide and other group violence*. Cambridge University Press.
- Tirrell, L. (2012). Genocidal language games. In I. Maitra & M. K. McGowan (Eds.), *Speech and harm: Controversies over free speech* (pp. 174–221). Oxford University Press.
- Urban Walker, M., (2006). *Moral repair*. Cambridge University Press.
- Watson, G. (1987). Responsibility and the limits of evil: Variations on a Strawsonian theme. In F. D. Schoeman (Ed.), *Responsibility, character, and the emotions* (pp. 256–286). Cambridge University Press.
- Wiesel, E. (1960). *Night*. Bantam Books.
- Williams, B. (1993). *Shame and necessity*. Harvard University Press.
- Williams, B. (1981). *Moral luck*. Cambridge University Press.
- Xu, X., Zuo, X., Wang, Z., & Han, S. (2009). Do you feel my pain? Racial group membership modulates empathy neural responses. *Journal of Neuroscience*, 29, 8525–8529. <https://doi.org/10.1523/JNEUROSCI.2418-09.2009>
- Zimbardo, P. (2007). *The Lucifer effect: Understanding how good people turn evil*. Random House.

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- Adams, M. M. (1999). *Horrendous evil and the goodness of God*. Cornell University Press.
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- Arendt, H. (1964). *Eichmann in Jerusalem: A report on the banality of evil* (2nd ed.). Penguin Books.
- Augustine. (1960). *Confessions*. Random House.
- Baumeister, R. F. (1997a). Esteem threat, self-regulatory breakdown, and emotional distress as factors in self-defeating behavior. *Review of General Psychology*, 1(2), 145-174. <https://doi.org/10.1037/1089-2680.1.2.145>
- Baumeister, R. F. (1997b). Identity, self-concept, and self-esteem: The self lost and found. In R. Hogan, J. A. Johnson, & S. R. Briggs (Eds.), *Handbook of personality psychology* (pp. 681-710). Academic Press. <https://doi.org/10.1016/B978-012134645-4/50027-5>
- Bartky, S. (1990). *Femininity and domination: Studies in the phenomenology of oppression*. Routledge.
- Bartky, S. (2002). *Sympathy and solidarity: And other essays*. Rowman & Littlefield.
- Calder, T. (2018). The concept of evil. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy*. Stanford University. <https://plato.stanford.edu/entries/concept-evil>. (Original work published 2013.)
- Card, C. (2002). *The atrocity paradigm: A theory of evil*. Oxford University Press.
- Card, C. (2010). *Confronting evils: Terrorism, torture, genocide*. Cambridge University Press.
- Diamond, C. (1978). Eating animals and eating people. *Philosophy*, 53(206), 465-479. <https://doi.org/10.1017/S0031819100026334>
- Donaldson, S., & Kymlicka, W. (2011). *Zoopolis: A political theory of animal rights*. Oxford University Press.
- Doris, J. M. (2002). *Lack of character*. Cambridge University Press.
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- Fanon, F. (1986). *Black skin, White masks*. Translated by Charles Lam Markmann. Pluto Press. (Original work published 1952.)
- Frankl, V. (1985). *Man's search for meaning*. Washington Square Press. (Original work published 1959.)
- Haidt, J. (2012). *The righteous mind: Why good people are divided by politics and religion*. Pantheon Books.
- Hick, J. (2010). *Evil and the God of love*. Palgrave and Macmillan. (Original work published 1966.)
- Hume, D. (1986). *A treatise of human nature*. Penguin: Random House. (Original work published 1739.)
- Isen, A. M., & Levin, P. F. (1972). Effect of feeling good on helping: Cookies and kindness. *Journal of Personality and Social Psychology*, 21(3), 384-388. <https://doi.org/10.1037/h0032317>
- Kizuk, S. (2020). "Settler shame: A critique of the role of shame in settler-indigenous Relationships in Canada." *Hypatia*, 35(1), 161-177. <https://doi.org/10.1017/hyp.2019.8>
- Langer, L. L. (1980). The dilemma of choice in the death camps. *Centerpoint: A Journal of Interdisciplinary Studies*, 4(1), 53-59. [Reprinted in J. K. Roth & M. Berenbaum (Eds.), *Holocaust: Religious and philosophical implications* (pp. 222-232). Paragon House.]

- Latané, B., & Rodin, J. (1969). A lady in distress: Inhibiting effects of friends and strangers on bystander intervention. *Journal of Experimental Social Psychology*, 5(2), 189–202. [https://doi.org/10.1016/0022-1031\(69\)90046-8](https://doi.org/10.1016/0022-1031(69)90046-8)
- Levi, P. (2017). *The drowned and the saved*. Simon & Schuster. (Original work published 1986, translated 1989)
- Levi, P. (1996). *Survival in Auschwitz* (S. Woolf, Trans.). Simon & Schuster. (Original work published 1958.)
- Mackie, J. L. (1955). Evil and omnipotence. *Mind*, 64 (254), 200–212. <https://www.jstor.org/stable/2251467>
- Marx, K. (2007). *Economic and philosophic manuscripts of 1844*. Dover.
- Miller, C. B. (2017). *The character gap: How good are we?* Oxford University Press.
- Milton, J. (2005). *Paradise lost*. Oxford University Press.
- Norcross, A. (2004). Puppies, pigs, and people: Eating meat and marginal cases. *Philosophical Perspectives*, 18(1), 229–245. <https://doi.org/10.1111/j.1520-8583.2004.00027.x>
- Prinz, J. (2011). Against empathy. *The Southern Journal of Philosophy*, 49(s1), 214–233. <https://doi.org/10.1111/j.2041-6962.2011.00069.x>
- Rediker, M. (2007). *The slave ship: A human story*. Viking Adult.
- Ross, L., & Nisbett, R. E. (1991). *The person and the situation: Perspectives of social psychology*. McGraw-Hill Book Company.
- Sartre, J. P. (1957) *Existentialism and human emotions* (B. Frechtman & H. E. Barnes, Trans.). Citadel Press.
- Schwitzgebel, E. (2019). Aiming for moral mediocrity. *RES Philosophica*, 96, 347–368. <https://doi.org/10.11612/resphil.1806>
- Singer, P. (2009). *Animal liberation*. Harper Collins. (Original work published 1975.)
- Staub, E. (1989). *The roots of evil: The origins of genocide and other group violence*. Cambridge University Press.
- Tirrell, L. (2012). Genocidal language games. In I. Maitra & M. K. McGowan (Eds.), *Speech and harm: Controversies over free speech* (pp. 174–221). Oxford University Press.
- Urban Walker, M., (2006). *Moral repair*. Cambridge University Press.
- Watson, G. (1987). Responsibility and the limits of evil: Variations on a Strawsonian theme. In F. D. Schoeman (Ed.), *Responsibility, character, and the emotions* (pp. 256–286). Cambridge University Press.
- Wiesel, E. (1960). *Night*. Bantam Books.
- Williams, B. (1993). *Shame and necessity*. Harvard University Press.
- Williams, B. (1981). *Moral luck*. Cambridge University Press.
- Xu, X., Zuo, X., Wang, Z., & Han, S. (2009). Do you feel my pain? Racial group membership modulates empathy neural responses. *Journal of Neuroscience*, 29, 8525–8529. <https://doi.org/10.1523/JNEUROSCI.2418-09.2009>
- Zimbardo, P. (2007). *The Lucifer effect: Understanding how good people turn evil*. Random House.

CHAPTER 17

Racial, Ethnic, and Immigration Intolerance: A Framework for Understanding Violence and Trauma

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CHAPTER OVERVIEW

This chapter focuses on the intolerance experienced by marginalized groups of people, based on race, ethnicity, and immigration status. It reviews current knowledge about violence-based trauma among minority groups and offers discussions that highlight historical patterns of and risk factors for PTSD. The chapter briefly summarizes interventions and treatments that

relate to race-based, ethnicity-based, historical, and intergenerational trauma.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Define ethnic, racial, and immigration intolerance and trauma as well as transgenerational trauma;
2. Develop greater awareness about the experience of violence-based and historical trauma among minority groups;
3. Recognize various factors that contribute to an increased risk for PTSD among individuals from minority racial backgrounds and among immigrants;
4. Discuss community protective factors related to treating trauma among populations affected by race-, ethnicity-, and immigration-related intolerance; and,
5. Identify appropriate interventions and treatments that are relevant to race-, ethnicity-, and immigration-based violence and trauma.

INTRODUCTION

Issues related to ethnicity and race have served as a prelude to social interactions throughout history and across national boundaries; they have become increasingly more volatile in the United States. Ethnicity and race have played a significant role in shaping immigration policy, politics, and reactions throughout U.S. history. Immigration has re-emerged as an important issue in ideological perception and public policy in the United States, as well as in many other Western nations. Political views pertaining to immigration among Americans especially are divided, with both support for and hate against the "other." For some, race and immigration evoke cultural and economic anxieties as well as raising concerns about the use of public resources. In contrast, for others, race and immigration represent a myriad of benefits to and new opportunities for the country.

Responses to contemporary notions about race, ethnicity, and immigration phenomena range from nativist and xenophobic reactions of alarm and fear to an appreciation of multicultural diversity and even the sense of an inevitable triumph of Democracy. In recent times, racism, xenophobia, and immigration restriction practices have created controversies over the lines historically drawn between races, between aliens and citizens, between "haves" and "have-nots," and between "us" and "them"; explosive tensions have been shared, and individuals and their families have been harmed, along with local communities and society in general. Intolerance of human beings, based on race, ethnicity, immigration status, and the intersectionality of any of these, either together or along with existing social inequities, is an area of high public salience, with significant implications for policy, social outcomes, and well-being.

Intolerance refers to a lack of acceptance of or hostility toward others, based explicitly on their minority status. Racial, ethnic, and immigration intolerance in America broadly is perceived to be on the rise in recent years, and research has documented an increase in manifestations of intolerant attitudes, both in national policy and more widely in the behaviors of individuals (e.g., [Quillian et al., 2017](#); [Shonkoff et al., 2021](#); [D. R. Williams, 2018](#)). Intolerance that is based on race, ethnicity, and immigration has a stressful impact on immigrants and racial- or ethnic-minority groups, causing emotional pain, suffering, and even trauma ([Gorski & Goodman, 2015](#); [Levers, 2020](#); [Levers & Hyatt-Burkhart, 2012](#); [Wilkerson, 2020](#); [M. T. Williams et al., 2021](#)).

In this chapter, we aim to broaden the usual conceptualization of violence and trauma as a theoretical framework by elaborating on the nature, causes, symptoms, and effects of racial, ethnic, and immigration-status intolerance. We specifically amplify this framework by offering discussions in the following sections: (a) Posttraumatic Stress Disorder in the Context of Race, Ethnicity, and Immigration Status; (b) Colonial Oppression; (c) Systemic Oppression and Immigration Intolerance; (d) Race-Based Hate Crimes; (e) Transgenerational Trauma; (f)

and immigration intolerance; (d) Race-Based Hate Crimes; (e) Transgenerational Trauma; (f) Trauma-Informed Interventions; and (g) Counseling Implications. Within these discussions, we propose a movement away from simplistic conceptualizations to richer engagement with a *humanizing* rather than *objectifying* context, one that supports racial, ethnic, and immigrant minority groups who far too often must deal with hate-based and historical trauma.

POSTTRAUMATIC STRESS DISORDER IN THE CONTEXT OF RACE, ETHNICITY, AND IMMIGRATION STATUS

Posttraumatic stress disorder (PTSD) is a serious condition that can develop after a person has witnessed or has experienced a traumatic event. The current diagnostic criteria for PTSD that appear in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) include cognitive, behavioral, and affective presentations of the disorder. Under "Criterion A," the *DSM-5* contains an important prerequisite for the identification and diagnosis of PTSD: a history of trauma exposure. Certain experiences that are not covered under the "Criterion A" umbrella still can cause a traumatic reaction. This has led to arguments for legitimizing exposure to oppressive and racist acts as traumatic events worthy of consideration in the diagnosis of PTSD. Scholars in the field state that exposure to race-, ethnicity-, or immigration-based hate acts can cause or trigger traumatic reactions (e.g., O'Neill et al., 2018; Shonkoff et al., 2021; D. R. Williams, 2018; M. T. Williams et al., 2018, 2021). The Anti-Defamation League (ADL, 2019) has constructed a *Pyramid of Hate* to illuminate the cascading societal attitudes that can lead to unthinkable acts of violence; a pertinent description and downloadable PDF of the pyramid are available on the ADL website (see References).

Race-, ethnicity-, and immigration-based trauma can be defined as a traumatic response to race-, ethnicity-, or immigration-related experiences that are collectively characterized as racism and xenophobia. Tenets of racism are based upon belief systems, held by individuals, that are deterministic in nature and premise the superiority of one group over another. However, as reported by the BBC (2020), a recent push to add "systemic oppression" to the formal definition of racism has been successful. Xenophobia commonly refers to a fear of strangers or those from other countries, and by extension, to an extreme dislike or even hatred of anything foreign. Both racism and xenophobia have led to overt or covert actions such as prejudice, discrimination, or violence against a perceived subordinate racial or immigrant group based on attitudes of superiority held by the dominant group. These covert or overt actions, carried out by individuals or societies, have the potential to cause racial- or immigration-based trauma.

Research shows that over time, the trauma begotten of race- or immigration-based intolerance can result in significant psychological and physiological damage in people of color and immigrants (Shonkoff et al., 2021; D. R. Williams, 2018). Race- or immigration-based traumatic stress is a shared experience among people of color and among immigrants. This cumulative and overwhelming emotional and psychological response to race- and hate-based trauma often is referred to as historical trauma. Historical trauma is an example of transgenerational trauma and consists of at least three factors: (1) the traumatic events result in collective suffering, (2) the event is widespread, and (3) the intent of those inflicting the trauma is malicious (O'Neill et al., 2018). Historical trauma grows out of the intolerance for and eventual devaluation and persecution of marginalized groups of people by some members of the dominant group; historical trauma clearly is a product of "othering."

The intolerance under scrutiny here has manifested, in far too many arenas, as White supremacist and White nationalist ideologies of exclusion and hatred. These ideologies embrace the perceived privilege of those who possess self-perceptions of "having power" over those viewed as "not worthy" of privilege or personal agency. According to Zalaquett and Haynes-Thoby (2020, p. 229), "These unearned privileges usually are not available to people of color. White privilege is mostly invisible to those who have it and, therefore, is very difficult to acknowledge." Sue et al. (2019) have referred to this phenomenon of invisibility as the *invisible veil*, thereby implying that racism has become so institutionalized that the very people who perpetrate its intolerance also are incapable of perceiving it, ostensibly without a

people who perpetrate its intolerance also are incapable of perceiving it, ostensibly without a mechanism for assisting them with some degree of self-awareness about the matter. Such “invisible” attitudes of intolerance cause great harm. For example, a former U.S. senator asserted the following, in an April 26, 2021 CNN broadcast (Lock, 2021, “Transcript of Santorum’s remarks on Native Americans,” para. 1-5):

If you think about this country, I don’t know of any other country in the world that was settled predominantly by people who were coming... here, mostly from Europe, and they set up a country.... We came here and created a blank slate. We birthed a nation from nothing. I mean, there was nothing here. I mean, yes, we have Native Americans but candidly there isn’t much Native American culture in American culture. It was born of the people who came here...

The “blank slate” narrative just presented is astonishing. It ignores the genocide of many of the indigenous peoples who inhabited the Americas, long before the arrival of European colonizers. It also ignores the forced abduction of many African peoples from their homelands, kidnapped to the “New World” and enslaved, in order to construct the very foundation for establishing the “dream” world reality of the colonizers. The factual history of the “founding of America” is far removed from any notion of “creating” a “blank slate”; indeed, statements of privilege, such as the one made by the senator, betray any sense of the sanctity of life, cause damage to others, and sustain the lived experiences of historical trauma.

The conceptualization of race-, ethnic-, and immigration-based violence and its effects can be viewed from varied theoretical approaches across different fields of studies. The following section illuminates the experiences of Black, Indigenous, and people of color (BIPOC), as well as immigrants, who have been exposed to traumatic events from an anticolonial lens. This anticolonial approach offers a way for understanding how colonial oppression and systemic racism can cause additional life stressors to those who have been oppressed and even harm their mental and physical health; this approach offers a critical discourse regarding individuals exposed to oppression as well as a discussion of how exposure to oppression affects their families and entire generations.

COLONIAL OPPRESSION

The word “colonize” derives from the Latin “colonus,” which means to inhabit, settle, farm, and cultivate. According to the Oxford English Dictionary (2021, “colonization,” p. 1), “colonization” describes “The action or process of settling among and establishing control over the indigenous people of an area ... [and] The action of appropriating a place or domain for one’s own use.” This definition indicates the taking over of land and resources, with or without violence and displacement. Most of us are familiar with the type of external colonization that we learned about in history courses, when people from one land move into and colonize another land, as was the case with European colonizers “conquering” the Americas or parts of the African, Asian, and Australian continents. However, scholars (e.g., Blauner, 1972, 2001) have posited an important distinction between external and internal colonization. Internal colonization occurs when a dominant culture undermines and exterminates another culture within the same area. Internal colonization is less obvious; it often is subconscious and more insidious.

In this section, we focus on the history and nature of internal colonization and the act of oppression in the United States. Even though the phenomenon of internal colonialism in the United States differs somewhat from other parts of the world, we hope that the focus on the United States can serve as an example for examining internal colonialism as a form of oppression that may exist in any given country. The theory of internal colonization explains the ways in which inequality and dominion are sustained within a society, even though a foreign power may not be in control. Internal colonization is a condition of oppression, and the term is used by social science scholars to conceptualize the historical and cultural conditions and experiences that result directly from the actions of imperial governments (Blauner, 2018).

Blauner (1972, 2001, 2018) provides a model to conceptualize colonialism and the oppressive nature of colonial acts. His model addresses four basic components of the

oppressive nature of colonial acts. His model addresses four basic components of the colonization complex: (a) forced, involuntary entry into a land and among its people; (b) destruction of indigenous culture, values, social orientation, and way of life; (c) imposition of legal order on the indigenous culture, by the invading culture, with an aim to dominate; and (d) justification of these actions through the use of prejudice, racist beliefs, and stereotypes (cited in [Canadian Association for Refugee and Forced Migration Studies \[CARFMS\], 2021](#), "colonization complex," p. 1). As defined by this complex, representatives of the dominant power regulate the lives of the subordinate group. This, in turn, establishes a principle of social domination and racism, by which a group is viewed as inferior or different; the alleged biological characteristics of the subordinate group members are exploited and controlled by the dominant group, and the dominant group oppresses the subordinate group socially and physically. Other scholars (e.g., [George, 2012](#); [Schaefer, 2015](#)) have described colonial oppression as a way to maintain control over a group's political, social, economic, and cultural capital and mores.

The history of the United States is written and taught from the perspective of the dominant culture. Even though the United State is among the most diverse democracies in the world, much of its history reveals an internal colonialism that has had traumatic consequences for minority groups and has affected subsequent generations. This history includes brutality against Native Americans and disregarding treaties with Native American Nations, internment of Japanese-American citizens during World War II, constitutionally encoded enslavement of Africans, as well as the racial profiling of Latinos, African Americans, and immigrants in general. [Table 17.1](#) summarizes the types of colonial oppressions, aimed at various groups in the United States, which have led to their experiences of historical trauma.

Racism in the United States is systemic and has very deep roots. We must excavate to the deepest levels to eradicate this toxic malevolence. We also must call out everyday acts of racism—what Hannah [Arendt \(1963\)](#) has identified as the "banality of evil." [Gorski and Goodman \(2015\)](#) have suggested that the area of multicultural counseling needs to be decolonized. [Goodman \(2015, p. 55\)](#) further states that the "creation of trauma-informed practices is a critical step forward ... because this framework acknowledges that trauma can have complex and long-lasting impacts on clients and must be addressed throughout all human services in order for our work to be effective." Following Gorski and Goodman, perhaps the entire arena of trauma counseling needs to be decolonized. While it is beyond the scope of this chapter to present the histories of all groups of oppressed people, in the following subsections, we discuss the colonial oppression of a few of the more highly targeted groups in the United States. We have selected groups that represent both indigenous people and immigrants, including those who already were here and were invaded, those who arrived willingly, those who fled dangerous conditions in their homelands, and those who were forcibly enslaved. We have elected to frame the discussion in terms of colonization, in order to reflect the multilayered dimensions and strata of historical trauma.

Table 17.1

Oppressive Acts and Traumatic Experience of Minority Groups

Oppressive Act	Group	Traumatic Experience as a Result of the Oppressive Act
Removal Act	Native American Nations	- Forced relocation (died of hunger, disease)
The Dawes Act		- Trail of Tears march (exhaustion)
		- Forced placement in boarding schools
		- Loss of tribal lands and erosion of tribal traditions
Constitutional encoding of enslavement	Africans	- Segregation
Chattel Slavery	African Americans	- Denied basic human rights

Slavery Abolished		- Enslavement
Ku Klux Klan		- Tortured
Lynching		- Prohibited from education
"Great migration"		- Restricted movement and behavior
Urbanizing Blacks		- Rape
		- Brutal punishment
Internment during World War II	Asian Americans	- Denied citizenship and naturalization
Chinese Exclusion Act		- Prevented from marrying Caucasians
		- Prevented from owning land
Racial profiling	Latinos/Hispanics	- Racism
	African Americans	- Racist biases
	Immigrants	- Exposure to racist abuse in the media
		- Discrimination
Crimmigration	Immigrants	- Harsh criminal sanctions
Between 2005 and 2015, anti-immigrant legislative acts increased by 500%, from 38 to 222		- Criminalizing certain migrant groups
		- Violence
		- Sanctions and injuries

Colonial Oppression and Native Americans

As a result of oppressive systems and policies designed by individuals from dominant European cultures, Native Americans have been subjected to internal colonialism. The act of internal colonization traumatized indigenous populations and caused the loss of many lives, loss of families, loss of land, and loss of culture for the last 500 years (Whitback et al., 2004). In 1830, President Andrew Jackson signed the Indian Removal Act, which authorized the federal government to relocate Native Americans, forcibly, to the southeast to create room for White settlements. This displacement caused the deaths of many Native Americans due to hunger, disease, and exhaustion on a forced march west of the Mississippi River. Additionally, in 1887, President Grover Cleveland passed the General Allotment Act, also known as the Dawes Act, which forcibly converted communally held tribal lands into small, individually owned lots and allowed the government to seize two-thirds of reservation lands and redistribute them to White Americans. These experiences caused the forced erosion of tribal traditions, the displacement of thousands of families, and the loss of 90 million acres of valuable land. The loss of tribal lands continued between 1945 and 1968, with federal laws terminating more than 100 tribal nations' recognition, thus placing them under state jurisdiction.

Indigenous peoples were forced onto "reservations," tracts of land that were not their tribal homes, but rather, spaces determined by the government. In some instances, tribal groups who were historical enemies were placed on the same reservation by legislators (Wyoming State Historical Society, 2018). The government removed indigenous children from their families and forced the children to attend government boarding schools, circa 1879, such as the Carlisle Indian Industrial School. Severing children from their families and indigenous cultures was another act of oppression that traumatized generations of Native Americans. Many of the children, dispossessed of their families and sent to these schools, experienced severe abuse and neglect, including regular physical and sexual assaults. Many of the schools were operated by religious organizations, and the abuse was at the hands of duly officiated members of religious groups. Contemporary Tribal Elders continue to share horrific memories about the school-based violence of their early childhood experiences (Pember,

memories about the school-based violence of their early childhood experiences ([Pember, 2019](#)).

Colonial Oppression and Asian Americans

People emigrating from Asia have had varied experiences upon arriving in the United States. Immigrants, along with U.S. citizens whose heritages have derived from China, Japan, India, other parts of Asia, and the Pacific Islands (both of Asian and indigenous heritage)—all people of color—are likely to have experienced discrimination in the United States. As a continuation of our discussion about colonial experiences, Asian Americans long have been considered as a “threat” to the nation, as the “other”; historically, they were looked down upon, considered to be of lower status, and they have been discriminated against, exploited, violently attacked, and murdered.

In the 19th century, Asian Americans were referred to as the “yellow peril” and viewed as “unclean,” which fueled the passage of the Chinese Exclusion Act, the first law that restricted immigration based on race. Although Chinese laborers largely were responsible for building the transcontinental railroad east, from California, the “Chinese Must Go” movement in 1880s was vehement and caused the decline of Chinese immigrants from 39,500 in 1882 to only 10 in 1887 ([Asia Society, 2021](#)). In 1924, all Asian immigrants, including Chinese, Japanese, Koreans, and Indians, with the exception of Filipino “nationals,” were fully excluded by law, denied citizenship and naturalization, and prevented from marrying Caucasians or owning land. Because of the U.S. colonization of the Philippines, many Filipinos emigrated to the United States to work. They were denigrated and reviled for supposedly being “unclean” and “uncivilized,” which was a standard trope for the “swarthy other” viewed through the lens of bigotry. In 1942, President Franklin Roosevelt’s Executive Order 9066 to isolate and incarcerate individuals, under suspicion as “enemy aliens,” served as the impetus for the internment of over 120,000 Japanese Americans during WWII. These instances constituted additional examples of the vile historical oppression against Asian Americans in the United States. Even though this Executive Order, along with earlier discriminatory laws, affected German and Italian Americans as well, the vast majority of those incarcerated in the early 1940s were of Japanese descent and lived in five west coast states. Many of them were second- and third-generation Americans—they were born in the United States, and they were citizens. Silence and attempts to assimilate into mainstream society were common coping reactions following the internment. The descendants of those who were interned have tried to cope with the trauma by seeking redress and by reviving connections with their Japanese heritage and culture ([Nagata et al., 2019](#)).

U.S. immigration laws remained discriminatory toward Asians until 1965, when, in response to the larger civil rights movement, nonrestrictive annual quotas of 20,000 immigrants per country were established. Fewer people have emigrated from other parts of Asia but nonetheless have experienced discrimination. Asian Americans from smaller countries like Viet Nam, Laos, Thailand, and Nepal have immigrated to the United States in immigration waves over the last several decades, often as refugees fleeing dangerous situations in their countries of origins. Asian Americans, like most marginalized groups, have been found to be at risk for mental health disparities. For example, PTSD, depression, anxiety, panic disorder, and other mental health disorders have been common in Cambodian and Vietnamese American refugees ([Constante, 2020](#)). Of course, immigration law in the United States has become a contentious issue, and vile, vicious, and pernicious perpetrations of racism against Asian Americans have reemerged as an artifact of misperceptions about and reactions to the COVID-19 pandemic.

Colonial Oppression and Africans/African Americans: Enslavement

During much of the 17th and 18th centuries, prominent U.S. citizens in all of the 13 colonies—both in the North and the South—incorporated slavery into accepted law ([Congress.Gov., n.d.](#)). Slavery was more than a labor system; it was an uneven, exploitative, and immoral covenant that, when threatened or endangered, gave White colonists an exaggerated sense of their own status of superiority, perpetuating their shared racial bond and identity. The

their own status of superiority, perpetuating their shared racial bond and identity. The practice of slavery continued on a large scale, even after it was declared illegal, which in and of itself was a complex issue, in terms of an historical date. The preliminary Emancipation Proclamation was signed in 1862, the Emancipation Proclamation was signed in 1863, and the 13th Amendment to the U.S. Constitution was passed in 1865; however, the pathway to freedom was paved with obstacles. During this time, captive Africans faced the challenge of surviving in a society that had avowed each of them as private property. They had no legal right to make decisions about their own lives and could be bought, sold, tortured, rewarded, educated, or killed at the slaveholder's will. Even after emancipation, freedom for African Americans has remained elusive; through Jim Crow laws, through the civil rights movement, through voter suppression, and through the contemporary Black Lives Matter movement, equity and justice, assumptive attributes of American Democracy encoded in law and in the Constitution, are not necessarily the quotidian reality of many Black lives in the United States.

The long legal—and ultimately de facto—existence of slavery helped to create the American caste system that endures today. [Wilkerson \(2020\)](#) brilliantly identified and examined eight pillars that undergird caste systems across civilizations, emphasizing how Nazi Germany assessed American racial systems as a means toward Jewish subjugation. The course of enslavement, its brutality and savagery, its contemporary retrograde to Jim Crow, has carried a high cost for African Americans, not the least of which is transgenerational or historical trauma. African Americans experience much higher rates of poverty, unemployment, educational disparity, and negative health outcomes compared to the majority group in the United States. The biopsychosocial disparities and possible epigenetic changes associated with historical trauma have further complicated well-being and life-span issues for African Americans ([Daskalakis et al., 2018](#)). The legacy of enslavement has shaped the entire contemporary situation of African Americans.

Oppressive ideas about African Americans and about Blackness, forged first through European and then “New World American” colonial violence, ultimately spread, influencing culture and even science for centuries. It also shaped the premise for an utter devaluation, by Whites and the systems they have controlled, of African American life in the United States. Scholars in the fields of sociology, anthropology, and psychology have argued that colonialism is at the root of the current trend of police violence against African Americans and their communities ([Bryant-Davis et al., 2017](#)). Present day policing practices that include brutality have manifested in the killings of George Floyd, Breonna Taylor, and so many others. These atrocities continue to mirror the colonialism that has shaped the history of African Americans since their earliest arrival, as enslaved Africans, in the 16th century (while captive Africans were brought to the Jamestown Colony in 1619, their initial arrival in North America was in the 1500s) ([Guasco, 2017](#)).

SYSTEMIC OPPRESSION AND IMMIGRATION INTOLERANCE

Many factors may influence the decision for a person to choose to emigrate from one location to another. Individuals, as well as entire families, may experience immigration-related trauma before, during, and after the immigration process ([Levers & Hyatt-Burkhart, 2012](#)). Immigration also can cause transgenerational trauma, as a person's or their family's reason to immigrate can affect their perceptions about the process. If a family is forced out of their homeland due to safety concerns, perhaps arising from persecution by their own people or even from a dominant culture, it can create stress and maybe trauma symptoms. Individuals may pass along traumatic symptomatology that affects their children's ability to trust other people or to create effective personal and interpersonal boundaries. Several issues may contribute to this type of transgenerational trauma.

First, in addition to the psychological effects of immigration, there are also environmental impacts on immigration. There often may be hundreds or thousands of people trying to reach resource officers to emigrate from their country-of-origin; however, long lines and the unavailability of people to help may hamper a sense of well-being during the immigration process. This could lead to extensive trauma for children or unaccompanied young adults who

are trying to immigrate without a guardian present. This type of trauma can cause mental health strains for these young individuals as they continue to develop and grow.

Second, culture plays an important role in the immigration process. During their journey to the United States, immigrants are at further risk of experiencing extortion, sexual assault, violence, robberies, kidnapping, exposure to extreme temperature resulting in hypothermia or hyperthermia, and even death. Trauma, in this capacity, could affect how individuals experience their direct environment, thus causing them to feel uneasy about what is happening around them. Again, this may add to the potential struggle with ongoing mental health concerns related to the immigration process.

Finally, immigrants face perhaps even greater psychological stressors after reaching their new destination. They often encounter additional and potentially traumatizing impediments that may threaten their well-being; these include racism, ethnocentrism, nativism, isolation, and fear of deportation. As they live in the United States, immigrants (e.g., African immigrants, Latinx immigrants, Asian immigrants, and other immigrants of color) often experience the negative effects of systemic oppression. They often are perceived as "outsiders" or "others" for many reasons, including differences in race, ethnicity, and immigration status. Othering is the process by which individuals who are perceived as "'different' in a given society are rejected and oppressed" (Chavez-Dueñas et al., 2019, p. 50).

Nativism, racism, and ethnocentrism contribute to trauma among immigrants, their families, and their communities. Nativist ideologies maintain cultural stereotypes about immigrant people, involving a number of unfounded negative perceptions that immigrants refuse to assimilate and refuse to learn the language of the new country, that they cause fiscal problems, and that generally they are not "legitimate" and are living in the country without proper authorization (Chavez-Dueñas et al., 2019). A resurgence of nativism in the United States has increased the likelihood of violence against immigrants, causing greater fear and trauma in immigrant communities.

Racial- and Ethnic-Based Trauma Among Immigrants

The levels of ethnic, racial, and immigration intolerance in America and other Western countries are perceived widely as being on the rise. Numerous reports from human rights advocacy groups have documented this rise and have expressed concern. According to the Council of Europe (2012), racism and intolerance have been on the rise in Europe, resulting in tensions that have led to racist violence. Reports by the Southern Poverty Law Center (2017, 2020, 2021) reflect parallel levels of hatred, rooted in racism and intolerance, in the United States.

The intolerance of migrants commonly is referenced as nativism. Nativism reflects the intersection of racism and nationalism, initiating an intense opposition to and intolerance of migrants, whom the nativists deem as foreign and therefore inferior (Vallejo, 2013). Nativist attitudes toward ethnic minorities arise, in part, from the belief that foreigners are a threat to the national culture. Intolerance toward immigrants centers on several interrelated themes. Race- and immigration-based stress involves any threatening or dangerous event, real or perceived, that leads to experiences of discrimination based on race or immigration status. According to Comas-Díaz et al. (2019), these include threats of harm, actual injury, any humiliating or shaming acts, and witnessing harm to other people of color or immigrants due to real or perceived racism or immigration intolerance. Immigrants may be exposed to traumatic events prior to their immigration as well as during their journey (Levers & Hyatt-Burkhart, 2012). They also may experience high levels of stress related to racism, ethnocentrism, and nativism once they arrive in the United States. This, in turn, may result in or exacerbate already-existing ethno-racial trauma among immigrants, which then can affect their mental health, well-being, and everyday functioning (Aranda & Vaquera, 2015). Chavez-Dueñas et al. (2019) have defined ethno-racial trauma as "the individual and or collective psychological distress and fear of danger that results from experiencing and witnessing discrimination, threats of harm, violence, and intimidation directed at ethno-racial minority groups or immigrants" (p. 49).

The links among racism, xenophobia, and trauma are evident in many social science studies

The links among racism, xenophobia, and trauma are evident in many social science studies (e.g., [Comas-Díaz & Jacobsen, 2001](#); [D. R. Williams, 2018](#); [M. T. Williams et al., 2021](#)). Research from a variety of academic fields provides various perspectives for conceptualizing and understanding the intersectionality of race, ethnicity, and immigration intolerance that comprises the trauma resulting from racism. Race- or immigration-based trauma does not occur in a vacuum and thereby is worsened by the cumulative impact of multiple traumas, such as community violence, victimization, and combat. From an ecological perspective, the race- and immigration-based violence that leads to trauma exists at interpersonal, environmental, institutional, and cultural levels; it affects the physical, emotional, psychological, and social health of individuals and communities.

RACE-BASED HATE CRIMES

Hate crimes are criminal acts that have been motivated, in whole or in significant part, “by bias against race, color, religion, national origin, sexual orientation, gender, gender identity, or disability” ([U.S. Department of Justice, n.d.](#), “Terminology,” p. 1). The Hate Crimes Statistics Act, which was signed into law by President George H. W. Bush in April 1990, created a voluntary program for police agencies to submit data to the FBI, through the attorney general; in the most recent report (at the time of writing), for 2020, there were 15,136 law enforcement agencies that had provided data (Federal Bureau of Investigations [[FBI](#)], 2021). To offer a general picture, hate crimes reported to police in America’s 10 largest cities rose 12.5% in 2017 ([Levin & Reitzel, 2018](#)). In contrast to the increase in hate crime in the 10 largest cities, the nation experienced a slight drop in crime during the first part of that same year, with the decrease in property crime being greater than in violent crime ([Levin & Reitzel, 2018](#)). Levin and Reitzel reported that, at the time, “The most common type of hate crime bias categories in the nation’s ten largest cities in 2017 were anti-Black, anti-Semitic, anti-gay and anti-Latino, but there was wide variation across different cities for this and other factors” (p. 8). However, anti-Asian hate crimes surged to 149%

in 2020, while overall hate crimes in the United States dropped by 7% in 2020 ([Center for the Study of Hate & Extremism, 2020](#)).

Race- and immigration-based hate crimes have been described as private or public behaviors that are intended to emphasize and devalue the status of minorities or a member of a minority group ([Abu-Rasm & Suarez, 2009](#)). Race-based hate crimes have been the most common types of hate crime, and they increased significantly between 2016 and 2019. According to the [U.S. Department of Justice \(2019a\)](#), 2018 hate crime statistics released by the FBI indicated that there were 7,036 single-bias incidents involving 8,646 victims and 84 multiple-bias hate crime incidents involving 173 victims. More than half of the incidents (59.6%) were race-, ethnic-, and ancestry-bias hate crimes. Figures reported to the FBI varied only slightly in 2019, with the following incidents of hate crime: 7,103 single-bias incidents involved 8,552 victims, and 211 multiple-bias hate crime incidents involved 260 victims ([U.S. Department of Justice, 2019b](#)).

Context of Race and Immigration-Based Trauma

Hate crimes may manifest as various forms of race-based harassment or discrimination. Hate crimes can look very different, depending on a number of factors; they may include various forms of murder, rape, assault, intimidation, or destruction of property ([Abu-Rasm & Suarez, 2009](#)). Hate crimes are used to intimidate individuals, manipulating or forcing them into submission. These events typically are traumatic to the individual who is experiencing them, but the events also can be traumatizing to the entire community or culture of the targeted individual; ultimately, hate crimes harm and degrade the whole society in which they occur. Such dynamics can perpetuate the symptomatology for transgenerational trauma. Victims of transgenerational trauma may experience an increase in fear, hopelessness, defensiveness, and vigilance; they may feel like the dominant culture is unwelcoming of their identity, which paradoxically may cause them to separate from their minority group status. This may be an effort, conscious or unconscious, to protect against potential further aggression; individuals may receive or communicate what [Cherepanov \(2020\)](#) has referred to as "survival messages." However, such trauma-based separation may disrupt important familial and cultural attachments; in the process of self-protective separation, individuals may lose important support systems, which in turn can inhibit continued recovery ([Abu-Rasm & Suarez, 2009](#); [Cherepanov, 2020](#)).

Effects of Race and Immigration-Based Trauma

The legacy of race- and immigration-based displacement, oppression, and unresolved grief across generations has affected not only individuals, but also has caused families and communities to endure higher levels of financial insecurity and poorer overall physical and mental health ([Comas-Díaz et al., 2019](#); [Duran, 2006](#); [Geter et al., 2018](#); [Rensink, 2011](#); [D. R. Williams, 2018](#); [M. T. Williams et al., 2021](#)). For example, according to a [U.S. Department of Health and Human Services report \(2021\)](#), the 2019 data showed that 20.3% of the American Indian/Alaska Native population lived at the poverty level, as compared to 9% of non-Hispanic Whites. As a result, members of this population have been at greater risk of experiencing psychological distress and are more likely to have poorer physical and mental health. Their suicide rates have been the highest of any racial/ethnic group in the United States and have been increasing since 2003 ([Leavitt et al., 2018](#)). Suicide has been the eighth-leading cause of death for American Indians and Alaska Natives, across all ages; suicide has been the second-leading cause of death for American Indian and Alaska Native youth from 10 to 24 years of age ([National Indian Council on Aging, 2019](#)).

Research has shown that trauma reactions from racism or ethno-violence can be as psychologically debilitating as trauma reactions from natural disasters and other events usually associated with trauma ([D. R. Williams, 2018](#)). The effects of violence, racism, and ethnic oppression heighten the risk of experiencing psychological harm. Race- and immigration-based trauma carries psychophysiological effects such as hypervigilance, flashbacks, nightmares, avoidance, suspiciousness, and somatic expressions like headaches

flashbacks, nightmares, avoidance, suspiciousness, and somatic expressions like headaches and heart palpitations, among others that are similar to PTSD symptoms (Comas-Díaz et al., 2019). Although racial trauma exhibits these similarities, it differs from PTSD. For example, according to Comas-Díaz et al. (2019, p. 2), "racial trauma involves ongoing injuries due to the exposure (direct and or vicarious) and re-exposure to race-based stressors." All of these psychological and physical effects of racial trauma also may cause hidden wounds among those who have been oppressed (Comas-Díaz et al., 2019; Geter et al., 2018; Rensink, 2011; D. R. Williams, 2018; M. T. Williams et al., 2021). One of the prominent effects of racial trauma is its transmission to the next and subsequent generations, even possibly effecting epigenetic changes (Daskalakis et al., 2018; Yehuda & Lehrner, 2018). The next section discusses how the impact of racial trauma passes from generation to generation.

TRANSGENERATIONAL TRAUMA

While theories about and understandings of intergenerational and transgenerational trauma are relatively new to the field of psychology, they have been receiving a lot of attention in recent years (Atkinson et al., 2014; Braga et al., 2012; DeAngelis, 2019; Yehuda & Lehrner, 2018). Simply stated, the construct of transgenerational trauma has offered a perspective about how parental exposure to extremely adverse events can have an impact not only on the parents' children but also on subsequent familial generations. Initially this idea was investigated after World War II, in response to the experiences of Holocaust survivors' children. In the mid-1960s, psychologists began to notice a significant number of children of Holocaust survivors, who were presenting with affective and emotional symptoms, transmitted from the previous generation, and who were seeking mental health treatment (Rakoff et al., 1966). Some of the symptoms included a mistrust of the dominant culture, an incapacity for expressing feelings, a continuous fear of danger, separation anxiety, unclear boundaries, and overprotection among family members (Braga et al., 2012, "Background," p. 4). Since that time, a number of field studies have provided evidence supporting the idea of intergenerational or transgenerational trauma and illuminating how parental trauma exposure can affect offspring (van Steenwyk et al., 2018). Researchers continue to investigate the experience of trauma passed from one generation to the next through the possible expression of epigenetic mechanisms (Daskalakis et al., 2018; Yehuda & Lehrner, 2018).

Transgenerational trauma can be caused by a multitude of different traumatic experiences; just a few types of examples include the effects of extreme poverty, a sudden or violent death of a family member, a crime against a family member, a parent or other family member dispatched to go to war, and the assault or torture of a family member. The impact of historical trauma typically is more complex than individual trauma. Historical trauma can affect a family's health and wellness negatively. It can result in a greater loss of identity, purpose, and meaning; this, in turn, can have an impact upon multiple generations, perhaps even "normalizing" the sequelae of the trauma. The National Child Traumatic Stress Network (2017) has reported that some of the common traumatic stress reactions related to race and immigration include "increased vigilance and suspicion, increased sensitivity to threat, sense of a foreshortened future, and more maladaptive responses to stress such as aggression or substance use" (p. 3).

Understanding the legacy of trauma, as it passes generationally, is key to understanding how families operate for generations to come (DeAngelis, 2019; van Steenwyk et al., 2018). Transgenerational trauma can affect how parents choose to raise their families. A family that has experienced transgenerational trauma may raise its children to be more cautious and distrusting of the dominant culture, as familial members were taught in that same manner. Or perhaps something happened within their lives which caused them to raise their family using a more conservative or cautious style. Massive transgenerational trauma, as with a genocide for example, can affect individuals, their families, communities, and entire societies profoundly and in multidimensional ways (Danieli, 1998; DeAngelis, 2019; Mukamana et al., 2019). Understanding transgenerational trauma can help mental health professionals in identifying patterns among affected people and families.

Another implication of transgenerational trauma includes better understandings of and

Another implication of transgenerational trauma includes better understandings of and working relationships both with the individuals and within the public health sector. If large populations of individuals who are experiencing transgenerational trauma are more ready to seek public health services, it allows more data to be collected about their lives. This could identify a plethora of variables that potentially can be linked together to create a fuller scaffold for working with these individuals. [Sotero \(2006\)](#) has suggested that gaining this invaluable information can lead to developing better training protocols, which in turn can enhance how individuals affected by historical trauma might adapt and readapt to the communities in which they live in. In addition, a broader public health perspective provides a context for understanding transgenerational trauma, thus allowing for better treatment interventions that can empower individuals to address their needs culturally, throughout the community, and to build resilience ([Ortega-Williams et al., 2021](#)).

Healing in the Context of Racial Trauma

Healing from racial trauma can be a challenging process ([Anderson & Stevenson, 2019](#)). The wounds caused by racial trauma occur within a sociohistorical and political context; they are complex, they typically recur, and they may traverse generations. Counseling with racial and ethnic groups of people who experience systemic racism, violence, and other forms of bias, particularly as a result of historical trauma, requires a framework for trauma recovery that concurrently addresses both the harm that has been inflicted and the strength and resiliency needed to overcome such discrimination ([Ortega-Williams et al., 2021](#)). Scholars and clinicians have developed a variety of approaches to assess, intervene with, and help recover from race-based trauma and historical trauma. However, the practice of cultural sensitivity, cultural competence, and cultural humility approaches to trauma comprises skill sets that still are under development. Moreover, the current definitions of “trauma,” “traumatic stress,” and “trauma treatment” are embedded in Euro-centric perspectives of counseling ([Goodman, 2015](#); [Gorski & Goodman, 2015](#); [Hernández-Wolfe, 2015](#); [Hook et al., 2017](#)). Consequently, many trauma and PTSD treatments tend to lack cultural relevance for most people with racial and ethnic minority backgrounds ([Hinton & Good, 2015](#)).

[Schnyder et al. \(2016\)](#) found that PTSD treatment-seeking survivors did not necessarily share their therapists’ cultural perspectives. The researchers concluded that clinicians working with PTSD clients needed to increase their cultural sensitivity and competence. Both researchers and clinicians need to contextualize their work with BIPOC who present with racial trauma symptoms, by using culturally responsive and racially informed interventions. Emergent work on race- and trauma-informed therapeutic approaches must draw upon individual and cultural resilience; enhancing and building resilience is key to advancing personal and collective transformation, healing, well-being, and recovery.

Multicultural Pluralism, Cultural Humility, Social Justice, and the Effects of Trauma

Multicultural pluralism has referenced situations in which a minority group, living within a larger majority group, is able to maintain its cultural identities and values ([Hook et al., 2017](#)). This type of coexistence has proven ideal, as it accepts and accounts for the qualities and values of both majority and minority groups. Coexistence has been positive for immigrants who are seeking a new way of life. This type of situation also has helped individuals who have experienced transgenerational or historical trauma to feel more welcomed and comfortable within the dominant society. It has been important for nondominant cultures to feel this acceptance and support from the dominant society. This can be fostered through social advocacy and social justice actions aimed at sensitizing and educating members of the dominant society. Those who have experienced transgenerational trauma can feel supported within their own culture but also sense acceptance by the dominant culture in order to prevent or reduce prolonged trauma symptomatology.

Cultural humility has been described as the ability to maintain an open perspective to the aspects of cultural identity that are important to the individuals of another culture ([Hook et al., 2017](#); [Waters & Asbill, 2013](#)). The notion of cultural humility has encouraged us all to

Hook et al., 2017; Waters & Asbill, 2013). The notion of cultural humility has encouraged us to develop the highest levels of cultural competency; the pathway to achieving this includes a lifelong commitment to being able to self-evaluate and critique self and others as well as an understanding of the imbalance in power among various groups within the population (Hook et al., 2017; Waters & Asbill, 2013). Minorities have not had a seat at the table in most aspects of life, as compared with the dominant culture. Therapists should advocate for these groups in order to promote equality and equity. Finally, cultural humility has been instrumental in developing partnerships with people and groups to promote advocacy and support throughout the community (Hook et al., 2017; Waters & Asbill, 2013).

Social justice has been defined as a societal state in which members have the same rights, opportunities, obligations, and social benefits (Turner & Pope, 2009). Social justice has played an important role in making sure that individuals feel supported and accepted. Clinicians may need to advocate for their clients' rights in order to aspire toward and produce positive social change. Those who have experienced transgenerational trauma need therapists who can advance their rights and advocate for social justice within the larger dominant culture.

All three of these systemic dynamics—multicultural pluralism, cultural humility, and social justice—constitute important skill sets for therapists to possess. These characteristics can aid therapists in being able to conduct their jobs ethically and to the fullest ability, helping to change the future, especially for clients who have "inherited" historical trauma. Additionally, these skills also are useful in understanding all clients and how best to serve them.

TRAUMA-INFORMED INTERVENTIONS

Healing race- and immigration-based trauma requires a focus on what Chavez-Dueñas et al. (2019, p. 55) refer to as "both the symptoms of the trauma (internal) and the interlocking systems of oppression (external) that cause and maintain psychological distress." Intervention for and treatment of race- and immigration-based trauma begin with understanding the symptoms of intergenerational and transgenerational trauma. At both personal and community levels, the symptoms of historical loss and trauma can manifest as societal-environmental, psychological, and physiological concerns. For example, intimate partner violence, physical violence, and sexual assault are three-and-a-half times higher than the national average in Native American communities (Sue et al., 2019), and Native American children are one of the most overrepresented groups in child protective services (National Conference of State Legislatures, 2021). Certain psychological issues can indicate the need to screen for a trauma history, across ethnic or racial groups. These may include high levels of alcohol consumption among any ethnic group, co-occurring disorders, substance abuse and mental health disorders, low or vacant self-esteem, loss of cultural identity, lack of positive role models, history of abuse and neglect, self-medication to numb emotional pain, feelings of hopelessness, and loss of familial and cultural connections (DeGruy, 2005; Sue et al., 2019). Members of minority groups, particularly BIPOC, are overrepresented in some types of healthcare problems, such as heart disease, tuberculosis, sexually transmitted diseases, and injuries. Metabolic diseases like diabetes are more prevalent among BIPOC than other racial groups in the United States. Life expectancy at birth for the Native American population, as one example, is 5.5 years less than that of all U.S. populations combined (Indian Health Service, 2019). In the remaining parts of this section, we discuss related assessment and treatment issues.

Clinical Assessment: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Framework*

Traumatic stress caused by racism, xenophobia, and racial trauma can be difficult to recognize due to many factors such as lack of clinician awareness, discomfort surrounding conversations about race in a clinical setting, and a lack of validated measures for its assessment. It is crucial for counselors to uncover racial trauma using culturally informed case conceptualization and exploration of client experiences of racism as a basis for the diagnosis of PTSD, when warranted. Even though connections between racism and trauma

diagnosis of PTSD, which warranted. Even though connections between racism and trauma are accepted and understood widely in the psychological literature, the lack of practical guidelines and assessment tools may hinder counselors in fully diagnosing and exploring the traumatic experiences of clients based on racial or immigration intolerance. One helpful assessment protocol is described in the text that follows.

Synthesizing the existing literature, existing measures for assessment of racial trauma, and accepted clinical practice, M. T. Williams et al. (2018) developed the *UConn Racial/Ethnic Stress and Trauma Survey* (UnRESTS). The UnRESTS is a semistructured clinician-administered interview protocol, designed specifically for use with clients who are members of stigmatized racial and ethnic groups. The UnRESTS protocol incorporates information and includes items that inquire about the racial and ethnic groups with which clients identify. The racial and ethnic identity sections of the protocol emphasize the client's socialization to race as well as how the person feels about and toward the racial/ethnic group. This information can inform the clinician about the context of the clients' distress. The assessment protocol allows counselors to explore clients' experiences related to explicit racism, both direct and vicarious, along with more subtle forms of racism, including microaggressions. The UnRESTS concludes with a checklist aimed at discovering if symptoms are present and whether they comport with *DSM-5* criteria for PTSD.

Clinical Treatment

In the mental health fields, numerous scientist-clinicians have developed approaches for treating and intervening with racial and intergenerational trauma (Chavez-Dueñas et al., 2019; Comas-Díaz, 2016; M. T. Williams et al., 2018). Common approaches in helping clients to recover from racial trauma range from psychotherapy, group counseling, and community methods to ethnopolitical interventions. One such community-based model, *Trauma-Informed Community Development* (TICD), is detailed in Chapter 19, "Historical Trauma and Trauma-Affected Communities," of this textbook; a second community-based intervention, HEART, is presented below.

Community-Based Intervention Framework: *Healing Ethno And Racial Trauma*

Chavez-Dueñas et al. (2019) have proposed a framework intended "to stimulate healing from ethno-racial trauma" (p. 49). They have titled this community-based intervention as the *Healing Ethno And Racial Trauma* model, or HEART. Comprised of four phases, the framework is grounded in the principles of liberation psychology and trauma-informed care. The phases are goal driven to ensure that counselors have culturally sensitive guidelines for "helping individuals, families, and communities to achieve growth, wellness, and healing" (p. 49). Although the framework originated with an aim toward helping Latinx immigrants to become aware of and to cope with the systemic oppression that causes ethno-racial trauma, we believe that this model can be of utility in working with various types of race- and immigration-based trauma. The four phases that comprise the HEART framework can be applied within the context of what Chavez-Dueñas et al. have identified as a sanctuary space, that is, a space in which individuals with racial/ethnic minority status are permitted to:

- (a) authentically express themselves, be affirmed, and acknowledged; (b) reprocess and mourn the losses associated with ethno-racial trauma; (c) integrate experiences of ethno-racial trauma and connect to cultural elements and practices that heal; and (d) create strategies for protecting, liberating, resisting, and organizing for social action. (p. 56)

The authors describe the intention behind each phase and offer suggestions for clinicians and clinician organizations to help clients navigate the four phases, described briefly in the text that follows.

Phase 1: Establishing Sanctuary Spaces for Individuals Experiencing Ethno-Racial Trauma

Clinicians can create a sense of physical and emotional safety through respect, validation, and affirmation with a focus on "assisting individuals, families, and communities [to] gain

and affirmation with a focus on “assisting individuals, families, and communities [to] gain immediate relief from the effects of psychological distress caused by ethno-racial trauma” (Chavez-Dueñas et al., 2019, p. 57).

Phase 2: Acknowledge, Reprocess, and Cope With Symptoms of Ethno-Racial Trauma

In Phase 2, Chavez-Dueñas et al. (2019) have encouraged counselors to shift their perspectives of trauma from a purely diagnostic and symptom-based perspective to one that contextualizes the lived experiences of marginalized clients. In this regard, the objectives of Phase 2 are to assist clients to “(a) acknowledge the impact of ethno-racial trauma, (b) process the experience in a sanctuary space, (c) develop culturally responsive ways of coping, and (d) contextualize their distress by challenging assumptions about the source(s) of their difficulties” (Chavez-Dueñas et al., 2019, p. 57).

Phase 3: Strengthen and Connect Individuals, Families, and Communities to Survival Strategies and Cultural Traditions That Heal

In this phase, Chavez-Dueñas et al. (2019) have promoted that counselors encourage connections as a means for building resilience and nurturing healing. This phase has focused on helping clients “to strengthen their connection with their culture, or build a connection if one does not exist” (Chavez-Dueñas et al., 2019, p. 57).

Phase 4: Liberation and Resistance

This phase has advanced a social justice orientation for immigrants. The activity of this phase has encouraged taking collective social action, based upon the premise that “healing takes place when people (a) gain awareness of the systemic roots of the challenges, and (b) learn strategies to act in ways that resist oppression and lead to social change” (Chavez-Dueñas et al., 2019, p. 59). Healing, in the form of liberation and resistance, becomes possible precisely because the process incorporates social justice action.

COUNSELING IMPLICATIONS

When working as a counselor, one of the most important aspects of treatment is the ability to understand a client’s trauma (George, 2012). Many individuals who have immigrated to a new country have a higher rate of trauma symptomatology, both physically and psychologically, and counselors need to understand this (de Arellano et al., 2018; Levers & Hyatt-Burkhart, 2012; Mpofu et al., 2021). Likewise, it is essential that clinicians understand and explore the lived experiences of daily microaggressions and historical trauma while working with clients who have experienced racial and ethnic trauma (Torres & Taknint, 2015). When counseling any clients who have experienced transgenerational trauma, it is imperative to assess for PTSD. In this context, PTSD may arise from hearing or witnessing a traumatic event(s) but it also can be learned from social roles and networks as well as from the acculturation stressors that are passed down from family members (George, 2012). Transgenerational trauma can be complicated, and it may present dense clinical dynamics, requiring extreme fortitude on the parts of both counselor and client in working through these issues in treatment. George has suggested that the best way to provide support for refugees is in a group setting. Group-based interventions, whether conducted with refugees or other members of minority or immigrant groups, must include a high level of cultural competency and operate from a strengths-based perspective. Cultural competency is necessary for understanding clients’ values, beliefs, and ethnicity, along with their social and cultural needs. Counselors need to understand the dynamics among individuals, their families, and their cultures. These factors play an important role in how a client interacts within the family, society, their own culture, and the dominant culture.

Transgenerational trauma can affect how a therapist and client may interact during their working relationship. Working with a family as a whole unit can allow for the family system to develop a level of trust and understanding without perpetuating ideas of separation. George (2012) advocates for using a strengths-based approach to empower clients to draw on their resilience. This resilience is anchored in the very act of their immigration to a new land and

resilience. This resilience is anchored in the very act of their immigration to a new land and in their ability to figure out how to operate within a new society. Maximizing internal strengths can enable clients to continue to face upcoming difficulties with greater positivity and generativity, thus improving the client's overall sense of well-being.

Weine et al. (2008) have suggested the *Coffee and Family Education and Support* (CAFES) intervention, which empowers individuals to work with their family members to foster support and champion wellness. The model encourages families to discuss issues that would help to decrease the effects of transgenerational trauma. Therapists can facilitate such conversations, thereby enabling family members to create a safe and trusting working environment for all who are involved. Additionally, George (2012) has stated that art therapy may be a useful tool for working with children who are at risk of experiencing transgenerational trauma. This strategy can encourage children to draw their environment and explore the different contexts of their lives. Art therapy also can allow therapists to address children's patterns of resilience through their various life experiences.

CONCLUSION

This chapter has presented a framework for understanding the violence and trauma that result from racial, ethnic, and immigration intolerance. In constructing this framework, we have offered discussions about context-based PTSD, various facets of oppression and transgenerational or historical trauma, trauma-informed interventions, and the counseling implications for working with clients who are affected by race-, ethnicity-, and immigration-based trauma. When counseling individuals and their families who have these experiences, it is important to understand their stories—their lived experiences—prior to creating treatment plans. A systems- or family-based approach seems to be one effective form of treatment, as it allows individuals to feel safe and to trust the therapeutic relationship. Additionally, a strengths-based approach reminds individuals of the profound resilience that they have manifest throughout their journeys. These approaches open communication among family members and reinforce their support systems. A strengths-based approach also improves the overall well-being of the individual's mental health. Trauma-informed treatment approaches include being sensitive to the individual and to the person's trauma narrative. Understanding and working with clients on various aspects of their lives can improve how they are interacting with their families and with other systems. Ultimately, it is important to be culturally competent in providing counseling, to be culturally sensitive to the trauma stories that are entrusted to us, and to demonstrate cultural humility in offering safe sanctuaries for people to heal from their trauma.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Video Resources

Post Traumatic Slave Syndrome. How Is It Different From PTSD? (2019; 5:47)
<https://www.youtube.com/watch?v=Rorgjdvphk>

Post Traumatic Slave Syndrome With Dr. Joy Degruy 2020 (34:06)
<https://www.youtube.com/watch?v=37evWT5ZUYA>

Helping a Patient With Racial Stress (3:39)

<https://www.youtube.com/watch?v=IBxYs2a2lbo&feature=youtu.be>

When Internalized Stereotypes Impact Depression (7:53)

<https://www.youtube.com/watch?v=mlbgBFxbnYQ&feature=youtu.be>

How to Address Blindspots and Racial Bias in a Session (5:18)

<https://www.youtube.com/watch?v=scfuHiBEL6Y&feature=youtu.be>

When a Client Makes Racist Comments (6:09)

<https://www.youtube.com/watch?v=4CauMzWTLpQ&feature=youtu.be>

Working With the Trauma of Racism (6:37)

<https://www.youtube.com/watch?v=egr2279UiAI&feature=youtu.be>

Addressing White Privilege in a Session (6:45)

https://www.youtube.com/watch?v=6dxft5_R8Gg&feature=youtu.be

Moving From Cultural Competence to Antiracism (6:09)

https://www.youtube.com/watch?v=_wJ_pvbC3SI&feature=youtu.be

Internal Colonization (6:42)

<https://study.com/academy/lesson/internal-colonialism-definition-examples.html>

Rabbit-Proof Fence (film; 2002; 93 minutes).

Website Resources

Without Sanctuary: Photographs and Postcards of Lynching in America:

<https://withoutsanctuary.org>

Project 1619:

<https://www.project1619.org>

REFERENCES

- Abu-Rasm, W. M., & Suarez, Z. E. (2009). Muslim men and women's perception of discrimination, hate crimes, and PTSD symptoms post 9/11. *Traumatology*, 15(3), 48-63. <https://doi.org/10.1177/1534765609342281>
- Alvarez, A. N., Liang, C. T. H., & Neville, H. A. (Eds.). (2016). *The cost of racism for people of color: Contextualizing experience of discrimination*. American Psychological Association.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- Anderson, R. E., & Stevenson, H. C. (2019). RECASTing racial stress and trauma: Theorizing the healing potential of racial socialization in families. *American Psychologist*, 74, 63-75. <https://doi.org/10.1037/amp0000392>
- Anti-Defamation League. (2019). *Pyramid of hate*. <https://www.adl.org/education/resources/tools-and-strategies/pyramid-of-hate-en-espanol>
- Aranda, E., & Vaquera, E. (2015). Racism, the immigration enforcement regime, and the implications for racial inequality in the lives of undocumented young adults. *Sociology of Race and Ethnicity*, 1(1), 88-104. <https://doi.org/10.1177/2332649214551097>
- Arendt, H. (1963). *Eichmann in Jerusalem: A report on the banality of evil*. Viking.
- Asia Society. (2021). *Asian Americans then and now: Linking past to present*. Center for Global Education. <https://asiasociety.org/education/asian-americans-then-and-now>
- Atkinson, J., Nelson, J., Brooks, R., Atkinson, C., & Ryan, K. (2014). Addressing individual and community transgenerational trauma. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd ed., pp. 289-307).

- lorres Strait Islander mental health and wellbeing principles and practice (2nd ed., pp. 289-301). Commonwealth of Australia. <https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/wt-part-4-chapt-17-final.pdf>
- BBC. (2020, June 10). *Racism definition: Merriam-Webster to make update after request*. <https://www.bbc.com/news/world-us-canada-52993306>
- Blauner, R. (1972). *Racial oppression in America*. Harper & Row.
- Blauner, R. (2001). *Still big news: Racial oppression in America*. Temple University Press.
- Blauner, R. (2018, May 29). *Internal colonialism*. *Encyclopedia of race and racism*. <https://www.encyclopedia.com/social-sciences-and-law/sociology-and-social-reform/sociology-general-terms-and-concepts/internal-colonialism>
- Braga, L. L., Mello, M. F., & Fiks, J. P. (2012). Transgenerational transmission of trauma and resilience: A qualitative study with Brazilian offspring of Holocaust survivors. *BMC Psychiatry*, 12, 134. <https://doi.org/10.1186/1471-244X-12-134>
- Bryant-Davis, T., Adams, T., Alejandre, A., & Gray, A. A. (2017). The trauma lens of police violence against racial and ethnic minorities. *Journal of Social Issues*, 73(4), 852-871. <https://doi.org/10.1111/josi.12251>
- Canadian Association for Refugee and Forced Migration Studies. (2021). *Colonialism. Online research and teaching tools*. [http://rfmsot.apps01.yorku.ca/theoretical-frameworks/colonialism/#:~:text=Robert%20Blauner%20identified%20four%20components,invading%20society%3B%20and%20\(4\)](http://rfmsot.apps01.yorku.ca/theoretical-frameworks/colonialism/#:~:text=Robert%20Blauner%20identified%20four%20components,invading%20society%3B%20and%20(4))
- Center for the Study of Hate & Extremism. (2020, March). *Fact sheet: Anti-Asian prejudice March 2020: Anti-Asian hate crime reported to police in America's largest cities: 2020*. California State University, San Bernardino. <https://www.csusb.edu/sites/default/files/FACT%20SHEET-%20Anti-Asian%20Hate%202020%203.2.21.pdf>
- Chavez-Dueñas, N. Y., Adames, H. Y., Prez-Chavez, J. G., & Salas, S. P. (2019). Healing ethno-racial trauma in Latinx immigrant community: Cultivating hope, resistance and action. *American Psychologist*, 74, 49-62. <http://dx.doi.org/10.1037/amp0000289>
- Cherepanov, E. (2020). *Understanding the transgenerational legacy of totalitarian regimes*. Routledge.
- Comas-Díaz, L. (2016). Racial trauma recovery: A race-informed therapeutic approach to racial wounds. In A. N. Alvarez, C. T. H. Liang, & H. A. Neville (Eds.), *Cultural, racial, and ethnic psychology book series. The cost of racism for people of color: Contextualizing experiences of discrimination* (pp. 249-272). American Psychological Association. <https://doi.org/10.1037/14852-012>
- Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist*, 74(1), 1-5. <http://doi.org/10.1037/amp0000442>
- Comas-Díaz, L., & Jacobsen, F. M. (2001). Ethnocultural allodynia. *The Journal of Psychotherapy Practice and Research*, 10(4), 246-252.
- Congress.Gov. (n.d.). *Africans in America: Life in a slave society*. Library of Congress. <https://www.loc.gov/classroom-materials/immigration/african/africans-in-america/#:~:text=Life%20in%20a%20Slave%20Society&text=During%20most%20of%20the%2017th,of%20the%20new%20United%20States>
- Constante, A. (2020, September 17). *Mental healthcare for Cambodian, Vietnamese refugees limited by shortage of bicultural, bilingual providers*. Daily Pilot. <https://www.latimes.com/socal/daily-pilot/entertainment/story/2020-09-17/mental-healthcare-for-cambodian-vietnamese-refugees-limited-by-shortage-of-bicultural-bilingual-providers>
- Council of Europe. (2012). *European commission against racism and intolerance*. <https://rm.coe.int/leaflet-ecri-2019/168094b101>
- Danieli, Y. (Ed.). (1998). *International handbook of multigenerational legacies of trauma*. Springer.
- Daskalakis, N. P., Rijal, C. M., King, C., Huckins, L. M., & Ressler, K. J. (2018). Recent genetics and epigenetics approaches to PTSD. *Current Psychiatry Reports*, 20, 30. <https://doi.org/10.1007/s11920-018-0898-7>
- DeAngelis, T. (2019). The legacy of trauma. *Monitor on Psychology*, 50(2), 36-52. <https://www.apa.org/monitor/2019/02/legacy-trauma>
- de Arellano, M. A., Andrews, A. R., Reid-Quinones, K., Vasquez, D., Silcott Doherty, L., Danielson, C. K., & Rheingold, A. (2018). Immigration trauma among Hispanic youth: Missed by trauma assessments and predictive of depression and PTSD symptoms. *Journal of Latina/o psychology*, 6(3), 159-174. <https://doi.org/10.1037/lat0000090>
- DeGruy, J. (2005). *Post traumatic slave syndrome: America's legacy of enduring injury and healing*. Uptone Press.
- Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other Native Peoples*. Teachers College Press.
- Federal Bureau of Investigation. (2021, August 30). *FBI releases 2020 hate crime statistics*. <https://www.fbi.gov/news/pressrel/press-releases/fbi-releases-2020-hate-crime-statistics>

<https://www.hhs.gov/news/press/2020/s0116-01>

Geter, A., Sutton, M. Y., Armon, C., Durham, M. D., Palella, F. J., Tedaldi, E., Hart, R., & Buchacz, K. (2018). Trends of racial and ethnic disparities in virologic suppression among women in the HIV Outpatient Study, USA, 2010–2015. *PLoS One*, 13(3), e0194413. <https://doi.org/10.1371/journal.pone.0194413>

George, M. (2012). Migration traumatic experiences and refugee distress: Implications for social work practice. *Clinical Social Work Journal*, 40, 429–437. <https://doi.org/10.1007/s10615-012-0397-y>

Goodman, R. D. (2015). A liberatory approach to trauma counseling: Decolonizing our trauma-informed practices. In R. D. Goodman & P. C. Gorski (Eds.), *Decolonizing “multicultural” counseling through social justice* (pp. 55–72). Springer.

Gorski, P. C., & Goodman, R. D. (2015). Introduction: Toward a decolonized multicultural counseling and psychology. In R. D. Goodman & P. C. Gorski (Eds.), *Decolonizing “multicultural” counseling through social justice* (pp. 1–12). Springer.

Guasco, M. (2017, September 13). *The misguided focus on 1619 as the beginning of slavery in the U.S. damages our understanding of American history*. Smithsonian Magazine. <https://www.smithsonianmag.com/history/misguided-focus-1619-beginning-slavery-us-damages-our-understanding-american-history-180964873>

Hernández-Wolfe, P. (2015). *A borderlands view on Latinos, Latin Americans, and decolonization: Rethinking mental health*. Rowman & Littlefield Publishers.

Hinton, B. J., & Good, D. (Eds.). (2015). *Culture and PTSD: Trauma in global and historical perspective*. University of Pennsylvania Press.

Hook, J. N., Davis, D., Owen, J., & DeBlaere, C. (2017). *Cultural humility: Engaging diverse identities in therapy*. American Psychological Association.

Indian Health Service. (2019). *Disparities*. U.S. Department of Health and Human Services. <https://www.ihs.gov/newsroom/factsheets/disparities/#:~:text=American%20Indians%20and%20Alaska%20Natives%20born%20today%20have%20a%20life,to%2078.5%20years%2C%20respectively>

Kimberg, L., & Wheeler, M. (2019). Trauma and trauma informed care. In M. R. Gerber (Ed.), *Trauma-informed healthcare approaches* (pp. 25–56). Springer.

Leavitt, R. A., Ertl, A., Sheats, K., Petrosky, E., Ivey-Stephenson, A., & Fowler, K. A. (2018). Suicides among American Indian/Alaska Natives — National violent death reporting system, 18 states, 2003–2014. *Morbidity and Mortality Weekly Report*, 67, 237–242. <http://doi.org/10.15585/mmwr.mm6708a1>

Levers, L. L. (2020). Crisis, disaster, and trauma. In L. L. Levers & D. Hyatt-Burkhart (Eds.), *Clinical mental health counseling: Practicing in integrated systems of care* (pp. 91–116). Springer Publishing.

Levers, L. L., & Hyatt-Burkhart, D. (2012). Immigration reform and the potential for psychosocial trauma: The missing link of lived human experience. *Analyses of Social Issues and Public Policy*, 12(1), 68–77. <https://doi.org/10.1111/j.1530-2415.2011.01254.x>

Levin, B., & Reitzel, J. D. (2018, May). *Report to the nation: Hate crimes rise in U.S. cities and counties in time of division & foreign interference: Compilation of official data (38 Jurisdictions)*. Center for the Study of Hate and Extremism; California State University, San Bernardino. <https://www.csusb.edu/sites/default/files/2018%20Hate%20Final%20Report%205-14.pdf>

Lock, S. (2021, April 27). *What did Rick Santorum say about Native Americans? Transcript of speech*. Newsweek. <https://www.newsweek.com/what-did-rick-santorum-say-about-native-americans-transcript-full-speech-1586628>

Mpofu, E., Nyiransekuye, H., & Levers, L. L. (2021). Identity development among African youth refugee immigrants to Australia. In S. S. Chuang, D. J. Johnson, S. Rasmi, & J. Glozman (Eds.), *Formation and identity: The intersectionality of development, culture, and immigration*. Springer.

Mukamana, D., Levers, L. L., Johns, K., Gishoma, D., Kayiteshonga, Y., & Ait Mohand, A. (2019). A community-based mental health intervention: Promoting mental health services in Rwanda. In S. Okpaku (Ed.), *Innovations in global mental health* (pp. 1–17). Springer Nature. https://link.springer.com/referenceworkentry/10.1007%2F978-3-319-70134-9_36-1

Nagata, D. K., Kim, J. H. J., & Wu, K. (2019). The Japanese American wartime incarceration: Examining the scope of racial trauma. *American Psychologist*, 74(1), 36–48. <https://doi.org/10.1037/amp0000303>

National Child Traumatic Stress Network, Justice Consortium, Schools Committee, and Culture Consortium. (2017). *Addressing race and trauma in the classroom: A resource for educators*. National Center for Child Traumatic Stress. https://www.nctsn.org/sites/default/files/resources/addressing_race_and_trauma_in_the_classroom_educators.pdf

National Conference of State Legislatures. (2021, January 26). *Disproportionality and race equity in child welfare*. <https://www.ncsl.org/research/human-services/disproportionality-and-race-equity-in-child-welfare.aspx>

National Indian Council on Aging. (2019, September 9). *American Indian suicide rate increases*. <https://www.nicoa.org/national-american-indian-and-alaska-native-hope-for-life->

<https://www.nccaa.org/national-american-indian-and-alaska-native-people-for-life-day/#:~:text=for%20Health%20Statistics,Native%20communities%20experience%20higher%20rates%20of%20suicide%20compared%20to%20all,Alaska%20Natives%20across%20all%20ages>

O'Neill, L., Fraser, T., Kitchenham, A., & McDonald, V. (2018). Hidden burdens: A review of intergenerational, historical and complex trauma, implications for indigenous families. *Journal of Child & Adolescent Trauma*, 11(2), 173-186. <https://doi.org/10.1007/s40653-016-0117-9>

Ortega-Williams, A., Beltrán, R., Schultz, K., Ru-Glo Henderson, Z., Colón, L., & Ciwang, T. (2021, January 22). An integrated historical trauma and posttraumatic growth framework: A cross-cultural exploration. *Journal of Trauma & Dissociation*, 22(2), 220-240. <https://doi.org/10.1080/15299732.2020.1869106>

Oxford English Dictionary. (2021). *Colonization*. Oxford Lexico. <https://www.lexico.com/en/definition/colonization>

Pember, M. A. (2019, March 8). *Death by civilization*. The Atlantic. <https://www.theatlantic.com/education/archive/2019/03/traumatic-legacy-indian-boarding-schools/584293>

Quillian, L., Pager, D., Hexel, O., & Midtbøen, A. H. (2017). *Meta-analysis of field experiments shows no change in racial discrimination in hiring over time*. PNAS. <https://doi.org/10.1073/pnas.1706255114>

Rakoff, V., Sigal, J. J., & Epstein, N. (1966). Children and families of concentration camp survivors. *Canada's Mental Health*, 14, 24-26.

Rensink, B. (2011). Genocide of Native Americans: Historical facts and historiographic debates. In S. Totten & R. K. Hitchcock (Eds.), *Genocide of indigenous peoples: Genocide: A critical bibliographic review* (Vol. 8, pp. 15-36). Transaction.

Schaefer, L. (2015). History and civility. *The NAMTA Journal*, 40(1), 104-111. <https://files.eric.ed.gov/fulltext/EJ1078021.pdf>

Schnyder, U., Bryant, R. A., Ehlers, A., Foa, E. B., Hasan, A., Mwit, G., Kristensen, C. H., Neuner, F., Oe, M., & Yule, W. (2016). Culture-sensitive psychotraumatology. *European Journal of Psychotraumatology*, 7, 31179. <https://doi.org/10.3402/ejpt.v7.31179>

Shonkoff, J. P., Slopen, N., & Williams, D. R. (2021). Early childhood adversity, toxic stress, and the impacts of racism on the foundations of health. *Annual Review of Public Health*, 42, 115-134. <https://doi.org/10.1146/annurev-publhealth-090419-10194>

Sotero, M. M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. *Journal of Health Disparities Research and Practice*, 2(1), 93-108.

Southern Poverty Law Center. (2017). *Ten ways to fight hate: A community resource guide*. https://www.splcenter.org/sites/default/files/com_ten_ways_to_fight_hate_2017_web.pdf

Southern Poverty Law Center. (2020). *Anti-Blackness & White nationalism: A call to Black America*. <https://www.splcenter.org/news/2020/10/05/anti-blackness-white-nationalism-call-black-america>

Southern Poverty Law Center. (2021). *The year in hate and extremism 2020*. <https://www.splcenter.org/news/2021/02/01/year-hate-2020>

Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counseling the culturally diverse: Theory and practice* (8th ed.). Wiley.

Torres, L. & Taknint, J. T. (2015). Ethnic microaggressions, traumatic stress symptoms, and Latino depression: A moderated mediational model. *Journal of Counseling Psychology*, 62(3), 393-401. <https://doi.org/10.1037/cou0000077>

Turner, S. L., & Pope, M. (2009). North America's native peoples: A social justice and trauma counseling approach. *Journal of Multicultural Counseling and Development*, 37, 194-205. <https://doi.org/10.1002/j.2161-1912.2009.tb00102.x>

U.S. Department of Health and Human Services. (2021). *Profile: American Indian/Alaska Native*. Office of Minority Health Resource Center. <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62>

U.S. Department of Justice. (2019a). *2018 hate crime statistics*. Federal Bureau of Investigation, Criminal Justice Information Services Division. <https://www.fbi.gov/news/stories/2018-hate-crime-statistics-released-111219>

U.S. Department of Justice. (2019b). *2019 hate crime statistics*. <https://www.justice.gov/hatecrimes/hate-crime-statistics>

U.S. Department of Justice. (n.d.). *Learn about hate crimes*. <https://www.justice.gov/hatecrimes/learn-about-hate-crimes>

Vallejo, J. A. (2013). Intolerance and migration, United States. In I. Ness (Ed.), *The encyclopedia of global human migration*. John Wiley & Sons. <https://doi.org/10.1002/9781444351071.wbeghm311>

van Steenwyk, G., Roszkowski, M., Manuella, F., Franklin, T. B., & Mansuy, I. M. (2018). Transgenerational inheritance of behavioral and metabolic effects of paternal exposure of traumatic stress in early postnatal life: Evidence in the 4th generation. *Environmental Epigenetics*, 4(2), dvy023. <https://doi.org/10.1093/eep/dvy023>

- Waters, A., & Asbill, L. (2013). *Reflections on cultural humility*. American Psychological Association. <https://www.apa.org/pi/families/resources/newsletter/2013/08/cultural-humility>
- Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, 33(3-4), 119-130. <https://doi.org/10.1023/B:AJCP.0000027000.77357.31>
- Weine, S., Kulauzovic, Y., Klebic, A., et al. (2008). Evaluating a multiple-family group access intervention for refugees with PTSD. *Journal of Marital and Family Therapy*, 34(2), 149-164. <https://doi.org/10.1111/j.1752-0606.2008.00061.x>
- Wilkerson, I. (2020). *Caste: The origins of our discontents*. Random House.
- Williams, D. R. (2018). Stress and the mental health of populations of color: Advancing our understanding of race-related stressors. *Journal of Health and Social Behavior*, 59(4), 466-485. <https://doi.org/10.1177/0022146518814251>
- Williams, M. T., Haeny, A. M., & Holmes, S. C. (2021). Posttraumatic stress disorder and racial trauma. *PTSD Research Quarterly*, 32(1), 1-9. https://www.ptsd.va.gov/publications/rq_docs/V32N1.pdf
- Williams, M. T., Metzger, I. W., Leins, C., & DeLapp, C. (2018). Assessing racial trauma within a DSM-5 framework: The UConn Racial/Ethnic Stress & Trauma Survey. *Practice Innovations*, 3(4), 242-260. <https://doi.org/10.1037/pri0000076>
- Wyoming State Historical Society. (2018). *The Arapaho arrive: Two nations on one reservation*. <https://www.wyohistory.org/encyclopedia/arapaho-arrive-two-nations-one-reservation>
- Yehuda, R., & Lehrner, A. (2018). Intergenerational transmission of trauma effects: Putative role of epigenetic mechanisms. *World Psychiatry*, 17(3), 243-257. <https://doi.org/10.1002/wps.20568>
- Zalaquett, C. P., & Haynes-Thoby, L. (2020). Contexts of cultural and systemic influence. In L. L. Levers & D. Hyatt-Burkhart (Eds.), *Clinical mental health counseling: Practicing in integrated systems of care* (pp. 215-242). Springer Publishing.

advocates for using a strengths-based approach to empower clients to draw on their resilience. This resilience is anchored in the very act of their immigration to a new land and in their ability to figure out how to operate within a new society. Maximizing internal strengths can enable clients to continue to face upcoming difficulties with greater positivity and generativity, thus improving the client's overall sense of well-being.

Weine et al. (2008) have suggested the *Coffee and Family Education and Support* (CAFES) intervention, which empowers individuals to work with their family members to foster support and champion wellness. The model encourages families to discuss issues that would help to decrease the effects of transgenerational trauma. Therapists can facilitate such conversations, thereby enabling family members to create a safe and trusting working environment for all who are involved. Additionally, George (2012) has stated that art therapy may be a useful tool for working with children who are at risk of experiencing transgenerational trauma. This strategy can encourage children to draw their environment and explore the different contexts of their lives. Art therapy also can allow therapists to address children's patterns of resilience through their various life experiences.

CONCLUSION

This chapter has presented a framework for understanding the violence and trauma that result from racial, ethnic, and immigration intolerance. In constructing this framework, we have offered discussions about context-based PTSD, various facets of oppression and transgenerational or historical trauma, trauma-informed interventions, and the counseling implications for working with clients who are affected by race-, ethnicity-, and immigration-based trauma. When counseling individuals and their families who have these experiences, it is important to understand their stories—their lived experiences—prior to creating treatment plans. A systems- or family-based approach seems to be one effective form of treatment, as it allows individuals to feel safe and to trust the therapeutic relationship. Additionally, a strengths-based approach reminds individuals of the profound resilience that they have manifest throughout their journeys. These approaches open communication among family members and reinforce their support systems. A strengths-based approach also improves the overall well-being of the individual's mental health. Trauma-informed treatment approaches include being sensitive to the individual and to the person's trauma narrative. Understanding and working with clients on various aspects of their lives can improve how they are interacting with their families and with other systems. Ultimately, it is important to be culturally competent in providing counseling, to be culturally sensitive to the trauma stories that are entrusted to us, and to demonstrate cultural humility in offering safe sanctuaries for people to heal from their trauma.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Video Resources

Post Traumatic Slave Syndrome. How Is It Different From PTSD? (2019; 5:47)
<https://www.youtube.com/watch?v=Rorgjdvphk>

Post Traumatic Slave Syndrome With Dr. Joy Degruy 2020 (34:06)

<https://www.youtube.com/watch?v=37evWT5ZUYA>

Helping a Patient With Racial Stress (3:39)

<https://www.youtube.com/watch?v=IBxYs2a2lbo&feature=youtu.be>

When Internalized Stereotypes Impact Depression (7:53)

<https://www.youtube.com/watch?v=mlbgBFxbnYQ&feature=youtu.be>

How to Address Blindspots and Racial Bias in a Session (5:18)

<https://www.youtube.com/watch?v=scfuHiBEL6Y&feature=youtu.be>

When a Client Makes Racist Comments (6:09)

<https://www.youtube.com/watch?v=4CauMzWTLpQ&feature=youtu.be>

Working With the Trauma of Racism (6:37)

<https://www.youtube.com/watch?v=egr2279UiAI&feature=youtu.be>

Addressing White Privilege in a Session (6:45)

https://www.youtube.com/watch?v=6dxft5_R8Gg&feature=youtu.be

Moving From Cultural Competence to Antiracism (6:09)

https://www.youtube.com/watch?v=_wj_pvbC3SI&feature=youtu.be

Internal Colonization (6:42)

<https://study.com/academy/lesson/internal-colonialism-definition-examples.html>

Rabbit-Proof Fence (film; 2002; 93 minutes).

Website Resources

Without Sanctuary: Photographs and Postcards of Lynching in America:

<https://withoutsanctuary.org>

Project 1619:

<https://www.project1619.org>

REFERENCES

Abu-Rasm, W. M., & Suarez, Z. E. (2009). Muslim men and women's perception of discrimination, hate crimes, and PTSD symptoms post 9/11. *Traumatology*, 15(3), 48-63.
<https://doi.org/10.1177/1534765609342281>

Alvarez, A. N., Liang, C. T. H., & Neville, H. A. (Eds.). (2016). *The cost of racism for people of color: Contextualizing experience of discrimination*. American Psychological Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).
<https://doi.org/10.1176/appi.books.9780890425596>

Anderson, R. E., & Stevenson, H. C. (2019). RECASTing racial stress and trauma: Theorizing the healing potential of racial socialization in families. *American Psychologist*, 74, 63-75.
<https://doi.org/10.1037/amp0000392>

Anti-Defamation League. (2019). *Pyramid of hate*. <https://www.adl.org/education/resources/tools-and-strategies/pyramid-of-hate-en-espanol>

Aranda, E., & Vaquera, E. (2015). Racism, the immigration enforcement regime, and the implications for racial inequality in the lives of undocumented young adults. *Sociology of Race and Ethnicity*, 1(1), 88-104. <https://doi.org/10.1177/2332649214551097>

Arendt, H. (1963). *Eichmann in Jerusalem: A report on the banality of evil*. Viking.

Asia Society. (2021). *Asian Americans then and now: Linking past to present*. Center for Global Education.
<https://asiasociety.org/education/asian-americans-then-and-now>

- Atkinson, J., Nelson, J., Brooks, R., Atkinson, C., & Ryan, K. (2014). Addressing individual and community transgenerational trauma. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd ed., pp. 289–307). Commonwealth of Australia. <https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/wt-part-4-chapt-17-final.pdf>
- BBC. (2020, June 10). *Racism definition: Merriam-Webster to make update after request*. <https://www.bbc.com/news/world-us-canada-52993306>
- Blauner, R. (1972). *Racial oppression in America*. Harper & Row.
- Blauner, R. (2001). *Still big news: Racial oppression in America*. Temple University Press.
- Blauner, R. (2018, May 29). *Internal colonialism*. *Encyclopedia of race and racism*. <https://www.encyclopedia.com/social-sciences-and-law/sociology-and-social-reform/sociology-general-terms-and-concepts/internal-colonialism>
- Braga, L. L., Mello, M. F., & Fiks, J. P. (2012). Transgenerational transmission of trauma and resilience: A qualitative study with Brazilian offspring of Holocaust survivors. *BMC Psychiatry*, 12, 134. <https://doi.org/10.1186/1471-244X-12-134>
- Bryant-Davis, T., Adams, T., Alejandre, A., & Gray, A. A. (2017). The trauma lens of police violence against racial and ethnic minorities. *Journal of Social Issues*, 73(4), 852–871. <https://doi.org/10.1111/josi.12251>
- Canadian Association for Refugee and Forced Migration Studies. (2021). *Colonialism. Online research and teaching tools*. [http://rfmsot.apps01.yorku.ca/theoretical-frameworks/colonialism/#:~:text=Robert%20Blauner%20identified%20four%20components,invading%20society%3B%20and%20\(4\)](http://rfmsot.apps01.yorku.ca/theoretical-frameworks/colonialism/#:~:text=Robert%20Blauner%20identified%20four%20components,invading%20society%3B%20and%20(4))
- Center for the Study of Hate & Extremism. (2020, March). *Fact sheet: Anti-Asian prejudice March 2020: Anti-Asian hate crime reported to police in America's largest cities: 2020*. California State University, San Bernardino. <https://www.csusb.edu/sites/default/files/FACT%20SHEET-%20Anti-Asian%20Hate%202020%203.2.21.pdf>
- Chavez-Dueñas, N. Y., Adames, H. Y., Prez-Chavez, J. G., & Salas, S. P. (2019). Healing ethno-racial trauma in Latinx immigrant community: Cultivating hope, resistance and action. *American Psychologist*, 74, 49–62. <http://dx.doi.org/10.1037/amp0000289>
- Cherepanov, E. (2020). *Understanding the transgenerational legacy of totalitarian regimes*. Routledge.
- Comas-Díaz, L. (2016). Racial trauma recovery: A race-informed therapeutic approach to racial wounds. In A. N. Alvarez, C. T. H. Liang, & H. A. Neville (Eds.), *Cultural, racial, and ethnic psychology book series. The cost of racism for people of color: Contextualizing experiences of discrimination* (pp. 249–272). American Psychological Association. <https://doi.org/10.1037/14852-012>
- Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist*, 74(1), 1–5. <http://doi.org/10.1037/amp0000442>
- Comas-Díaz, L., & Jacobsen, F. M. (2001). Ethnocultural allodynia. *The Journal of Psychotherapy Practice and Research*, 10(4), 246–252.
- Congress.Gov. (n.d.). *Africans in America: Life in a slave society*. Library of Congress. <https://www.loc.gov/classroom-materials/immigration/african/africans-in-america/#:~:text=Life%20in%20a%20Slave%20Society&text=During%20most%20of%20the%2017th,of%20the%20new%20United%20States>
- Constante, A. (2020, September 17). *Mental healthcare for Cambodian, Vietnamese refugees limited by shortage of bicultural, bilingual providers*. Daily Pilot. <https://www.latimes.com/socal/daily-pilot/entertainment/story/2020-09-17/mental-healthcare-for-cambodian-vietnamese-refugees-limited-by-shortage-of-bicultural-bilingual-providers>
- Council of Europe. (2012). *European commission against racism and intolerance*. <https://rm.coe.int/leaflet-ecri-2019/168094b101>
- Danieli, Y. (Ed.). (1998). *International handbook of multigenerational legacies of trauma*. Springer.
- Daskalakis, N. P., Rijal, C. M., King, C., Huckins, L. M., & Ressler, K. J. (2018). Recent genetics and epigenetics approaches to PTSD. *Current Psychiatry Reports*, 20, 30. <https://doi.org/10.1007/s11920-018-0898-7>
- DeAngelis, T. (2019). The legacy of trauma. *Monitor on Psychology*, 50(2), 36–52. <https://www.apa.org/monitor/2019/02/legacy-trauma>
- de Arellano, M. A., Andrews, A. R., Reid-Quinones, K., Vasquez, D., Silcott Doherty, L., Danielson, C. K., & Rheingold, A. (2018). Immigration trauma among Hispanic youth: Missed by trauma assessments and predictive of depression and PTSD symptoms. *Journal of Latina/o psychology*, 6(3), 159–174. <https://doi.org/10.1037/lat0000090>
- DeGruy, J. (2005). *Post traumatic slave syndrome: America's legacy of enduring injury and healing*. Uptone Press.
- Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other Native Peoples*. Teachers College Press.

Teachers College Press.

Federal Bureau of Investigation. (2021, August 30). *FBI releases 2020 hate crime statistics*. <https://www.fbi.gov/news/pressrel/press-releases/fbi-releases-2020-hate-crime-statistics>

Geter, A., Sutton, M. Y., Armon, C., Durham, M. D., Palella, F. J., Tedaldi, E., Hart, R., & Buchacz, K. (2018). Trends of racial and ethnic disparities in virologic suppression among women in the HIV Outpatient Study, USA, 2010–2015. *PLoS One*, 13(3), e0194413. <https://doi.org/10.1371/journal.pone.0194413>

George, M. (2012). Migration traumatic experiences and refugee distress: Implications for social work practice. *Clinical Social Work Journal*, 40, 429–437. <https://doi.org/10.1007/s10615-012-0397-y>

Goodman, R. D. (2015). A liberatory approach to trauma counseling: Decolonizing our trauma-informed practices. In R. D. Goodman & P. C. Gorski (Eds.), *Decolonizing “multicultural” counseling through social justice* (pp. 55–72). Springer.

Gorski, P. C., & Goodman, R. D. (2015). Introduction: Toward a decolonized multicultural counseling and psychology. In R. D. Goodman & P. C. Gorski (Eds.), *Decolonizing “multicultural” counseling through social justice* (pp. 1–12). Springer.

Guasco, M. (2017, September 13). *The misguided focus on 1619 as the beginning of slavery in the U.S. damages our understanding of American history*. Smithsonian Magazine. <https://www.smithsonianmag.com/history/misguided-focus-1619-beginning-slavery-us-damages-our-understanding-american-history-180964873>

Hernández-Wolfe, P. (2015). *A borderlands view on Latinos, Latin Americans, and decolonization: Rethinking mental health*. Rowman & Littlefield Publishers.

Hinton, B. J., & Good, D. (Eds.). (2015). *Culture and PTSD: Trauma in global and historical perspective*. University of Pennsylvania Press.

Hook, J. N., Davis, D., Owen, J., & DeBlare, C. (2017). *Cultural humility: Engaging diverse identities in therapy*. American Psychological Association.

Indian Health Service. (2019). *Disparities*. U.S. Department of Health and Human Services. <https://www.ihs.gov/newsroom/factsheets/disparities/#:~:text=American%20Indians%20and%20Alaska%20Natives%20born%20today%20have%20a%20life,to%2078.5%20years%2C%20respectively>

Kimberg, L., & Wheeler, M. (2019). Trauma and trauma informed care. In M. R. Gerber (Ed.), *Trauma-informed healthcare approaches* (pp. 25–56). Springer.

Leavitt, R. A., Ertl, A., Sheats, K., Petrosky, E., Ivey-Stephenson, A., & Fowler, K. A. (2018). Suicides among American Indian/Alaska Natives — National violent death reporting system, 18 states, 2003–2014. *Morbidity and Mortality Weekly Report*, 67, 237–242. <http://doi.org/10.15585/mmwr.mm6708a1>

Levers, L. L. (2020). Crisis, disaster, and trauma. In L. L. Levers & D. Hyatt-Burkhart (Eds.), *Clinical mental health counseling: Practicing in integrated systems of care* (pp. 91–116). Springer Publishing.

Levers, L. L., & Hyatt-Burkhart, D. (2012). Immigration reform and the potential for psychosocial trauma: The missing link of lived human experience. *Analyses of Social Issues and Public Policy*, 12(1), 68–77. <https://doi.org/10.1111/j.1530-2415.2011.01254.x>

Levin, B., & Reitzel, J. D. (2018, May). *Report to the nation: Hate crimes rise in U.S. cities and counties in time of division & foreign interference: Compilation of official data (38 Jurisdictions)*. Center for the Study of Hate and Extremism; California State University, San Bernardino. <https://www.csusb.edu/sites/default/files/2018%20Hate%20Final%20Report%205-14.pdf>

Lock, S. (2021, April 27). *What did Rick Santorum say about Native Americans? Transcript of speech*. Newsweek. <https://www.newsweek.com/what-did-rick-santorum-say-about-native-americans-transcript-full-speech-1586628>

Mpofu, E., Nyiransekuye, H., & Levers, L. L. (2021). Identity development among African youth refugee immigrants to Australia. In S. S. Chuang, D. J. Johnson, S. Rasmi, & J. Glozman (Eds.), *Formation and identity: The intersectionality of development, culture, and immigration*. Springer.

Mukamana, D., Levers, L. L., Johns, K., Gishoma, D., Kayiteshonga, Y., & Ait Mohand, A. (2019). A community-based mental health intervention: Promoting mental health services in Rwanda. In S. Okpaku (Ed.), *Innovations in global mental health* (pp. 1–17). Springer Nature. https://link.springer.com/referenceworkentry/10.1007%2F978-3-319-70134-9_36-1

Nagata, D. K., Kim, J. H. J., & Wu, K. (2019). The Japanese American wartime incarceration: Examining the scope of racial trauma. *American Psychologist*, 74(1), 36–48. <https://doi.org/10.1037/amp0000303>

National Child Traumatic Stress Network, Justice Consortium, Schools Committee, and Culture Consortium. (2017). *Addressing race and trauma in the classroom: A resource for educators*. National Center for Child Traumatic Stress. https://www.nctsn.org/sites/default/files/resources/addressing_race_and_trauma_in_the_classroom_educators.pdf

National Conference of State Legislatures. (2021, January 26). *Disproportionality and race equity in child welfare*. <https://www.ncsl.org/research/human-services/disproportionality-and-race-equity-in-child-welfare.aspx>

welfare.aspx

- National Indian Council on Aging. (2019, September 9). *American Indian suicide rate increases*. <https://www.nicoa.org/national-american-indian-and-alaska-native-hope-for-life-day/#:~:text=for%20Health%20Statistics-,Native%20communities%20experience%20higher%20rates%20of%20suicide%20compared%20to%20all,Alaska%20Natives%20across%20all%20ages>
- O'Neill, L., Fraser, T., Kitchenham, A., & McDonald, V. (2018). Hidden burdens: A review of intergenerational, historical and complex trauma, implications for indigenous families. *Journal of Child & Adolescent Trauma*, 11(2), 173-186. <https://doi.org/10.1007/s40653-016-0117-9>
- Ortega-Williams, A., Beltrán, R., Schultz, K., Ru-Glo Henderson, Z., Colón, L., & Ciwang, T. (2021, January 22). An integrated historical trauma and posttraumatic growth framework: A cross-cultural exploration. *Journal of Trauma & Dissociation*, 22(2), 220-240. <https://doi.org/10.1080/15299732.2020.1869106>
- Oxford English Dictionary. (2021). *Colonization*. Oxford Lexico. <https://www.lexico.com/en/definition/colonization>
- Pember, M. A. (2019, March 8). *Death by civilization*. The Atlantic. <https://www.theatlantic.com/education/archive/2019/03/traumatic-legacy-indian-boarding-schools/584293>
- Quillian, L., Pager, D., Hexel, O., & Midtbøen, A. H. (2017). *Meta-analysis of field experiments shows no change in racial discrimination in hiring over time*. PNAS. <https://doi.org/10.1073/pnas.1706255114>
- Rakoff, V., Sigal, J. J., & Epstein, N. (1966). Children and families of concentration camp survivors. *Canada's Mental Health*, 14, 24-26.
- Rensink, B. (2011). Genocide of Native Americans: Historical facts and historiographic debates. In S. Totten & R. K. Hitchcock (Eds.), *Genocide of indigenous peoples: Genocide: A critical bibliographic review* (Vol. 8, pp. 15-36). Transaction.
- Schaefer, L. (2015). History and civility. *The NAMTA Journal*, 40(1), 104-111. <https://files.eric.ed.gov/fulltext/EJ1078021.pdf>
- Schnyder, U., Bryant, R. A., Ehlers, A., Foa, E. B., Hasan, A., Mwit, G., Kristensen, C. H., Neuner, F., Oe, M., & Yule, W. (2016). Culture-sensitive psychotraumatology. *European Journal of Psychotraumatology*, 7, 31179. <https://doi.org/10.3402/ejpt.v7.31179>
- Shonkoff, J. P., Slopen, N., & Williams, D. R. (2021). Early childhood adversity, toxic stress, and the impacts of racism on the foundations of health. *Annual Review of Public Health*, 42, 115-134. <https://doi.org/10.1146/annurev-publhealth-090419-10194>
- Sotero, M. M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. *Journal of Health Disparities Research and Practice*, 2(1), 93-108.
- Southern Poverty Law Center. (2017). *Ten ways to fight hate: A community resource guide*. https://www.splcenter.org/sites/default/files/com_ten_ways_to_fight_hate_2017_web.pdf
- Southern Poverty Law Center. (2020). *Anti-Blackness & White nationalism: A call to Black America*. <https://www.splcenter.org/news/2020/10/05/anti-blackness-white-nationalism-call-black-america>
- Southern Poverty Law Center. (2021). *The year in hate and extremism 2020*. <https://www.splcenter.org/news/2021/02/01/year-hate-2020>
- Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counseling the culturally diverse: Theory and practice* (8th ed.). Wiley.
- Torres, L. & Taknint, J. T. (2015). Ethnic microaggressions, traumatic stress symptoms, and Latino depression: A moderated mediational model. *Journal of Counseling Psychology*, 62(3), 393-401. <https://doi.org/10.1037/cou0000077>
- Turner, S. L., & Pope, M. (2009). North America's native peoples: A social justice and trauma counseling approach. *Journal of Multicultural Counseling and Development*, 37, 194-205. <https://doi.org/10.1002/j.2161-1912.2009.tb00102.x>
- U.S. Department of Health and Human Services. (2021). *Profile: American Indian/Alaska Native*. Office of Minority Health Resource Center. <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62>
- U.S. Department of Justice. (2019a). *2018 hate crime statistics*. Federal Bureau of Investigation, Criminal Justice Information Services Division. <https://www.fbi.gov/news/stories/2018-hate-crime-statistics-released-111219>
- U.S. Department of Justice. (2019b). *2019 hate crime statistics*. <https://www.justice.gov/hatecrimes/hate-crime-statistics>
- U.S. Department of Justice. (n.d.). *Learn about hate crimes*. <https://www.justice.gov/hatecrimes/learn-about-hate-crimes>
- Vallejo, J. A. (2013). Intolerance and migration, United States. In I. Ness (Ed.), *The encyclopedia of global human migration*. John Wiley & Sons. <https://doi.org/10.1002/9781444351071.wbeghm311>
- van Steenwyk, G., Roszkowski, M., Manuella, F., Franklin, T. B., & Mansuy, I. M. (2018). Transgenerational inheritance of behavioral and metabolic effects of paternal exposure of traumatic stress in early

- inheritance of behavioral and metabolic effects of paternal exposure of traumatic stress in early postnatal life: Evidence in the 4th generation. *Environmental Epigenetics*, 4(2), dvy023. <https://doi.org/10.1093/eep/dvy023>.
- Waters, A., & Asbill, L. (2013). *Reflections on cultural humility*. American Psychological Association. <https://www.apa.org/pi/families/resources/newsletter/2013/08/cultural-humility>
- Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, 33(3-4), 119-130. <https://doi.org/10.1023/B:AJCP.0000027000.77357.31>
- Weine, S., Kulauzovic, Y., Klebic, A., et al. (2008). Evaluating a multiple-family group access intervention for refugees with PTSD. *Journal of Marital and Family Therapy*, 34(2), 149-164. <https://doi.org/10.1111/j.1752-0606.2008.00061.x>
- Wilkerson, I. (2020). *Caste: The origins of our discontents*. Random House.
- Williams, D. R. (2018). Stress and the mental health of populations of color: Advancing our understanding of race-related stressors. *Journal of Health and Social Behavior*, 59(4), 466-485. <https://doi.org/10.1177/0022146518814251>
- Williams, M. T., Haeny, A. M., & Holmes, S. C. (2021). Posttraumatic stress disorder and racial trauma. *PTSD Research Quarterly*, 32(1), 1-9. https://www.ptsd.va.gov/publications/rq_docs/V32N1.pdf
- Williams, M. T., Metzger, I. W., Leins, C., & DeLapp, C. (2018). Assessing racial trauma within a DSM-5 framework: The UConn Racial/Ethnic Stress & Trauma Survey. *Practice Innovations*, 3(4), 242-260. <https://doi.org/10.1037/pri0000076>
- Wyoming State Historical Society. (2018). *The Arapaho arrive: Two nations on one reservation*. <https://www.wyohistory.org/encyclopedia/arapaho-arrive-two-nations-one-reservation>
- Yehuda, R., & Lehrner, A. (2018). Intergenerational transmission of trauma effects: Putative role of epigenetic mechanisms. *World Psychiatry*, 17(3), 243-257. <https://doi.org/10.1002/wps.20568>
- Zalaquett, C. P., & Haynes-Thoby, L. (2020). Contexts of cultural and systemic influence. In L. L. Levers & D. Hyatt-Burkhart (Eds.), *Clinical mental health counseling: Practicing in integrated systems of care* (pp. 215-242). Springer Publishing.

CHAPTER 18

Understanding and Responding to Affectional and Transgender Prejudice and Victimization

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II

CHAPTER OVERVIEW

In addition to traumas that heterosexual and cisgender people experience, queer and transgender people face a heterosexist and cissexist culture, in which marginalization and trauma against them is normalized or minimized. In this chapter, the experience of hate crimes and violence, relational and interpersonal trauma, religious based-trauma, and sociocultural and political-based trauma are covered in relation to how it impacts Lesbian, Gay, Bisexual, Trans, and Queer (LGBTQ) people. Clinical and counseling implications are discussed. The increase in mental health challenges is explained via the minority stress model. Implications for diagnosis and trauma-informed practices for queer and transgender people are discussed. Additionally, the role of the mental health professional as a social justice advocate is explored, including how social justice frameworks can be incorporated in the counseling environment.

LEARNING OBJECTIVES

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After reading this chapter, the reader should be able to:

1. Define key terminology including sex, gender, gender expression, and gender identity, as well as affectional orientation identities;
2. Describe unique stressors and experiences of trauma specific to queer and transgender communities and people;
3. Describe the psychological, social, and emotional effects of trauma on queer and transgender communities and people;
4. Identify implications and unique clinical considerations within counseling and counselor education, including diagnosis and evidence-based interventions, using a clinical vignette; and,
5. Identify actions and steps, working from a social justice and advocacy lens, specific to queer and transgender communities and people.

INTRODUCTION

Queer and transgender people face a world in which they receive the message about who they are, at the core of their being, and that who they are is wrong, immoral, devalued, and even despised. Despite progress in human rights legislation and increasing societal acceptance, queer and transgender people continue to face marginalization, prejudice, discrimination, harassment, bullying, and violence ([Federal Bureau of Investigation \[FBI\], 2019](#); [Kosciw et al., 2018](#)). The purpose of this chapter is to explore the important aspects of trauma for mental health professionals to consider for this population. Relevant definitions are offered, along with examining the context in which queer and transgender people experience these various forms of trauma: a world with heterosexism and cissexism. The most common types of trauma, including hate crimes, relational trauma, religious-based trauma, and sociocultural and political-based trauma, are discussed. Implications for counseling and for social justice advocacy are explored, along with narratives, a case study, and reflection questions. The resources and references (online only) also serve as sources for further learning on this topic.

RELEVANT DEFINITIONS

A key concept to understand, in considering trauma for queer and trans populations, is the difference between sex and gender identity. **Sex** refers to the classification made by a medical or birthing professional at birth; babies, after a cursory external examination, are designated male, female, or intersex (a difference of sex development where a child has ambiguous genitalia or a combination of a penis, scrotum, and labia/vagina; [Ginicola et al., 2017](#)). While this cursory examination considers external genitals, it typically does not consider (unless the child is identified as intersex) an examination of their internal genitalia, chromosomes, or the child's internal sense of their gender, that is, their self-awareness of and personal sense of gender ([Ginicola et al., 2017](#)). Gender is "the feelings, attitudes, and behavior associated with a person's sex," experienced and expressed through a cultural lens ([Ginicola et al., 2017](#), p. 362). As children grow up in a culture, the norms and expectations for gendered differences are learned through exposure to the culture; children quickly learn what colors, dress, behavior, and personality characteristics are associated with a specific gender within their culture ([Martin & Ruble, 2010](#)). Within this context, children develop their own gender identity, which includes their deeply internal feelings and sense of self that surround being male, female, neither, other-gendered, or a combination of genders; gender identity also similarly involves their own internal sense of masculinity, femininity, and/or other-gendered self ([Ginicola et al., 2017](#)). Research indicates that evidence of gender identity can be seen as early as 18 months in all children and is typically stable and consistent by the time the child reaches 3 to 4 years of age ([Martin & Ruble, 2010](#)). People may express their gender externally through their demeanor, body language, activities, behavior, clothing, and

usually through their demeanor, body language, activities, behavior, clothing, and hairstyle, among others—a concept termed “gender expression.” A person may identify with a binary conception of gender—male versus female, or may identify as trans/transgender (T), which is a person whose gender identity does not align with the sex they were designated at birth (Ginicola et al., 2017). People may identify as a trans man, trans woman, or with a nonbinary identity, which can be agender (no gender within their identity), other-gendered (another gender beyond the binary of male or female), gender-expansive, or a combination of genders (Ginicola et al., 2017).

While understanding of one’s own gender develops first, understanding of a person’s affectional identity is usually experienced in childhood or adolescence (Ginicola et al., 2017). Whereas gender is an understanding of who one is, affectional identity is an understanding of who one loves (Ginicola et al., 2017). Affectional identity is the “direction in which one is predisposed to bond emotionally, physically, sexually, psychologically, and spiritually with others” (Ginicola et al., 2017, p. 359). Once called sexual orientation, counseling and psychology organizations have moved to replace this term, as it emphasizes sexual behavior over other bonding, which is not an accurate depiction (Harper et al., 2013). The term “sexual orientation” also excludes persons who identify as asexual (A), which are persons who feel little to no sexual attraction toward other persons but may feel and express romantic love (Ginicola et al., 2017). Within these identities, people may identify as lesbian (L; female-identified person who bonds with other female persons), gay male (G; male-identified person who bonds with other male persons), bisexual (B) and pansexual (P; which are both referring to a person who bonds with people from similar and other genders), queer (Q; an umbrella term for all affectional identities, and an individual identity that is not reflected, experienced, and/or expressed in conventional heterosexual or gay terms), or asexual, among other identities (Ginicola et al., 2017). Within the research, these communities are often collectively referred to as Affectional and Gender Minorities (AGM).

CONTEXT

Heterosexism is the assumption that all individuals do or should identify as heterosexual and perpetuates heterosexuality as the normative experience (Harper et al., 2013). Cissexism is the assumption that all individuals have a gender identity that is aligned with the sex and gender assigned to the individual at birth (Ginicola et al., 2017; Harper et al., 2013). Along with racism, sexism, and nativism, heterosexism has been intentionally woven into the legal and social structure of our society (Koski et al., 2019). Cissexism is embedded in the academy and social research (Lombardi, 2018). The presence of any “ism” fosters the conditions for marginalization and assigning lowered worth and value to those within those populations (Davis et al., 2020). Queer and transgender people exist within this context that devalues their identities, which has an impact on all people’s internal and external sense of the acceptability of queerness and nonheterosexual or cisgender identities.

The existence of queer and transgender people challenges the cisnormative and heteronormative social norms, which can lead to the direct and indirect experience of homophobia and transphobia. This challenge can manifest as an “aversion, fear, hatred, or intolerance” toward queer and trans people (Harper et al., 2013, p. 41). It is this challenge to the heterosexual and cisgender expectation of identity that causes queer and trans people to experience discrimination, oppression, and violence. An individual’s identity as queer or trans in itself is not a risk factor. Rather, experiencing heterosexism and cissexism in response to one’s identity, is a risk factor for traumatization and continued experiences of re-traumatization. Queer and trans people live in a constant battle to liberate themselves from heterosexist and cissexist sociocultural constraints. The lived experience of queer and trans people is one of *experiencing* and *surviving* multiple and repeated forms of trauma (Harper et al., 2013).

MOST COMMON TYPES OF TRAUMA

The term “trauma” is one that can refer to both an event and consequences from experiencing that event. Therefore, when someone says that a person has been through a

experiencing that event. Therefore, when someone says that a person has been through a trauma, it is unclear whether they mean that they have lived through a catastrophic incident, are exhibiting the signs of traumatization, or both. Potentially traumatic events (PTE) are those events that are regarded as threatening to one's life or physical safety, or witnessing that threat occur against someone else, or sexual violence. However, not all traumatic events result in symptomatology such as posttraumatic stress, dissociation, depression and anxiety, substance use, eating disorders, and so on. Thus, one can experience trauma without being traumatized. However, one cannot be described as traumatized without first having experienced a trauma ([American Psychiatric Association \[APA\], 2013](#)).

This warrants further discussion as to the definition of trauma events. The field often distinguishes between big "T" traumas and little "t" traumas. Big "T" traumas, as previously referenced, follow closely in line with the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; [APA, 2013](#)) diagnosis of Posttraumatic Stress Disorder (PTSD). Criterion A in the *DSM-5* defines and requires an event to precipitate the symptoms associated with posttraumatic stress. Some examples that would meet this definition of a trauma event, and are relevant in the AGM community, include sexual assault, intimate partner violence (IPV), physical violence, hate violence, urban violence, and threatened death or violence. The effects of such trauma events may lead to Criteria B to E: symptoms of avoidance, hyperarousal, intrusion, and negative thoughts and mood ([APA, 2013](#)).

Little "t" trauma events and experiences often co-occur with big "T" trauma events. Where the *DSM-5* would define a trauma event as life-threatening, little "t" trauma events are regarded as ego-threatening. Some specific examples include inadequate access to behavioral and medical healthcare, stigmatization and discrimination, internalized homophobia, biphobia, and transphobia, as well as homelessness and unemployment. These examples are unified by one commonality: they occur and are present at the hands of collective others. That is, being denied access to housing, employment, and healthcare is systemic and organizational, as well as personal (e.g., being denied employment after interviewing and presenting one's gender expression as noncisgender). Stigmatization and discrimination are macro-level events as well (e.g., laws and regulations that exist that are not directly targeting one specific individual), but often manifest in personalized interactions (e.g., inappropriate or hateful remarks, being denied an opportunity or service). None of the aforementioned examples threaten the physical integrity or mortality of an individual, yet they may, and often do, result in minority stress and trauma responses (e.g., [Meyer, 2003](#); [Stenersen et al., 2019](#)).

Hate Crimes Against This Population

Definition and Prevalence

The FBI defines a "hate crime" as a "criminal offense against a person or property motivated in whole or in part by an offender's bias against a race, religion, disability, sexual orientation, ethnicity, gender, or gender identity" ([FBI, 2019](#), Hate Crimes section). According to the [FBI \(2019\) Hate Crime Statistics](#), a report that includes data submitted by over 16,000 law enforcement agencies and provides information pertaining to the offenses and victims, people with AGM identities are at an increased risk of being victims of hate crimes. Roughly 17.4% of all hate crimes reported were motivated by the offender's affectional (15.8%) and gender identity (1.6%) biases. Similarly, [Herek \(2009\)](#) found that in a study of 662 LGB-identified individuals, 20% of participants reported having experienced a crime related to their affectional identities. In a special report by Human Rights Campaign (HRC; [Marzullo & Libman, 2009](#)), affectional identity was the third highest motivator reported in all hate crimes. It is important to note that these rates are also very likely to be underestimates; [Marzullo and Libman \(2009\)](#) further noted that hate crimes against LGBTQ individuals are underreported for various reasons including the fact that victims may not wish to "out" themselves when reporting. Additionally, AGM identity-biased hate crimes may be underreported by officers and agencies due to lack of experience and education on these topics as well as the officer's own biases. Officers' strong religious fundamentalism, overall negative attitudes toward LGBTQ persons, victim blaming, a general lack of criminal justice training, and lack of applied experiences with discussing affectional identities are all

training, and lack of applied experiences with discussing affectional identities are all predictors of an AGM hate crime being mishandled (Marzullo & Libman, 2009).

Experiencing Hate Crimes

Given the information on increased rates of hate crimes that are experienced by individuals based on their AGM identities, it is important to discuss the adverse consequences associated with experiencing such crimes. Hate crimes carry additional negative consequences, because they target a person's identity, and this is particularly salient when those identities are consistently subjected to *stigma-related stress* (i.e., expectations of rejection, fear of victimization; Meyer, 2003; Pachankis, 2007) as is the case with respect to AGM identities. Individuals with AGM identities live in a state of fear of being a victim of a hate crime and are forced to make decisions whether to conceal their identities in order to protect themselves (Herek, 2009).

Additionally, research has demonstrated a link between hate crimes and significant psychological distress and suicide among AGM individuals (e.g., Duncan & Hatzenbuehler, 2014; Herek, 2009). Heidt et al. (2005) reported higher incidents of reported depressive symptoms, PTSD, and overall psychological distress in a study of AGM individuals who experienced crimes related to their sexual identity. Herek (2009) expanded on this phenomenon and discussed the constructs of *felt stigma* and *enacted stigma* in relation to *criminal victimization* in a sample of 662 participants and concluded that the "psychological toll" that hate crimes take on the well-being of AGM individuals should be closely considered by mental health professionals and researchers moving forward (p. 9).

It is also important to note the intersection of minority stress (discussed further in the *Clinical and Counseling Implications* section, in the text that follows) experienced by AGM individuals and the resulting expectations of rejection and internalized homophobia (Meyer, 2013). The long-term effects of lived experiences of minority stress, coupled with the devastating psychological distress experienced as a result of hate crimes based on sexual and gender identities, can have detrimental effects on individuals who hold these identities and results in increased prevalence of suicidal ideation and attempts. In a study of sexual minority youths, Duncan and Hatzenbuehler (2014) demonstrated a significant correlation between living in neighborhoods with higher LGBTQ assault crimes and reported suicidal ideation and attempts. Specifically, AGM individuals from these neighborhoods were significantly more likely to report both suicidal ideation and attempts (Duncan & Hatzenbuehler, 2014).

Multiple Losses—Relational and Interpersonal Trauma

Relational or interpersonal trauma (IPT), often referred to as complex trauma or complex relational trauma, is the prolonged and repeated experience of stress that is characterized by feeling trapped, rejection, betrayal, violation of boundaries, confusion, and feelings of helplessness within a significant relationship (Schore, 2013). Relational trauma can look like bullying, harassment, abuse (physical, emotional, or psychological), threats of violence, perpetration of violence, rejection, and destruction of healthy attachment in significant relationships (Herman, 1992, 2015). Beginning in childhood, the prevalence of IPT has been shown to be higher for queer and trans identified individuals in comparison to heterosexual children (Balsam et al., 2005; Roberts et al., 2010). IPT has been conceptualized in the literature as primarily occurring among children who experience long-term abuse or maltreatment during their developmental years (Herman, 2015; Schore, 2013). This characterization fails to acknowledge that experiencing and surviving in relational trauma can happen across the life-span. The nature of experiencing relational trauma is that it is prolonged, repeated, and ambient (Schore, 2013).

Queer and transgender people are also at an increased risk of experiencing relational trauma within the workplace in the form of prejudice and discrimination (Chung et al., 2009). Affectional identity has also been correlated with higher rates of burnout (Rabelo & Cortina, 2014; Viehl & Dispenza, 2015), as well as lower job satisfaction as a result of workplace heterosexism (Lyons et al., 2005; Velez et al., 2013; Waldo, 1999). Rabelo and Cortina (2014)

heterosexism (Lyons et al., 2005; Velez et al., 2013; Waldo, 1999). Rabelo and Cortina (2014) noted that these negative workplace experiences included harassment, discrimination, and “sex stereotypes” by heterosexual colleagues.

The long-term effects of experiencing relational trauma during developmental years have been studied (Schore, 2013). What remains unexamined is the experience of individuals who encounter relational trauma across the life-span, and withstand the long-term effects, while continuing to be exposed to relational trauma from multiple sources. Queer and trans people are affected by relational trauma, beginning in childhood, and continue to experience and re-experience this trauma through adolescence and adulthood. The ways in which queer and trans people experience prejudice, discrimination, oppression, and violence have been examined in the literature; however, characterizing these experiences as forms of relational trauma has not yet been examined.

Research also has indicated that queer people are more likely to be at higher risk for child sexual abuse (CSA); Xu and Zheng (2017) found that 24% of gay men and 21% of bisexual men reported CSA, while 37% of lesbian women and 36% of bisexual women report CSA. This is compared to 8% of heterosexual men and 18% of heterosexual women (Pereda et al., 2009). Lesbian, gay, and bisexual individuals experience IPV, all forms of sexual violence, and stalking at rates equal to or higher than that of heterosexual individuals (Walters et al., 2013). These types of violence disproportionately affect bisexual women with approximately 46% experiencing rape in their lifetime (Walters et al., 2013). Compared to 21% of heterosexual men who report experiencing sexual violence, approximately 40% of gay men and 47% of bisexual men experience some form of sexual violence in their lifetime (Walters et al., 2013). When interpreting this data, it is crucial to remember that these numbers may not reflect the full scope of victimization of queer people, as many instances go unreported for fear of further violence, being outed, or not being believed. Additionally, demographic data about sexual and affectional identity is not always collected in local, state, and national surveys measuring victimization and violence.

Religious-Based Trauma

An area in which queer and trans people may also readily experience trauma is through their religious communities, particularly those linked to their families of origin. Often used as a rationale for the harassment and violence toward queer and trans people, religion has been weaponized in the current culture as *religious freedom* legislation, giving permission to discriminate openly and legally against queer and trans people (American Civil Liberties Union, 2020). The experience of religious-based trauma often is described as the experience of spiritual abuse (Oakley & Kinmond, 2013). Spiritual abuse is a deeply emotional attack, “coercion and control of one individual by another in a spiritual context” (Oakley & Kinmond, 2013, p. 21).

The perpetrators of spiritual abuse may not only be religious leaders, but also family members who ascribe to a disaffirming religion that holds a dogmatic belief system that rejects gender and affectional variance as abnormal and sinful (Oakley, 2009). Perpetrators of spiritual abuse may not only be unaware of the traumatic impact of their behavior on their victim, they also may feel and express that they are acting in accordance with a moral imperative and that their cruelty is, in fact, kindness (Blue, 1993). Because disaffirming religions are accepted in the mainstream, these religious messages, paired with the disaffirming cultural context, can be isolating and confusing for the victim—as they receive multiple messages regarding the devaluing of their identities in multiple contexts, which may compound their experience of trauma and internalization of the abuse (Oakley & Kinmond, 2013).

For a person growing up in such a religious context, their understanding of who they are as a queer or trans person, as well as the meanings associated with their AGM identities, can be experienced as problematic, abnormal, and also as a threat—to their soul, their families, and their communities (Wolkomir, 2006). In a study by Ginicola and Smith (2016), one participant reflected the following:

I grew up in Southern Mississippi, in a place where Baptist is the only religion. My parents were, and still

I grew up in Southern Mississippi, in a place where Baptist is the only religion. My parents were, and still are, ultra conservative Evangelical Christians. We were in a church every time the doors opened. ... I heard a sermon ... concerning homosexuality. 'If a man lie with a man as he lieth with a woman' ... In that moment, I had two revelations: one, I am a homosexual, and two, I am going to burn in hell for all eternity.

Often these experiences may render a victim feeling powerless and disconnected from reality; their experience of themselves does not match what is being told to them as absolute truth (Oakley & Kinmond, 2013). If an individual reaches out to a disaffirming family member or a religious leader, disclosing their experience and their identity, the individual may not only discredit their experience, but attempt to convince them that their sense of reality is distorted, leaving the victim confused and disconnected from their realities and perceptions (Oakley & Kinmond, 2013).

Leaving the abuser or abusing institution becomes incredibly difficult; in many cases, the primary source of support and community is also the primary source of victimization and abuse (Kinmond & Oakley, 2015). Breaking away from the abuse may occur gradually or very abruptly (Winell, 2006). However, even with breaking away, the psychological, physical, spiritual, and emotional damage continues to be carried with the survivor (Winell, 2006). In addition to many survivors reporting loss of their spirituality, they also report posttraumatic symptoms, which would meet *DSM-5* Criteria (Criteria B, C, D, & E; APA, 2013; Wehr, 2000; Winell, 2006).

Sociocultural- and Political-Based Trauma

Legal victories such as the end of "Don't Ask, Don't Tell" and the passage of federal marriage equality would give the impression that queer and trans people are free of sociocultural- and political-based trauma. The passage of sweeping legislation supports the idea that queer and trans people are now equal, in their protection and freedom under the law, to heterosexual people. Despite advances in the movement for equality, these two landmark victories do not represent the end of the fight for queer and trans liberation (Ball, 2019).

Relying on these victorious policies to signal equality for queer and trans people fails to recognize a foundational component of equality, which is equity. Sociocultural factors such as political policies, political attitudes, and religious discourse continue to influence attitudes (Israel et al., 2011) toward queer and trans people. This broadens the gap between groups within queer and trans communities who remain systemically oppressed. Many queer and trans people continue to work without legal protections for their jobs, as this legislation is left to be determined at the state and local levels. Queer and trans people face discrimination from faith-based organizations that hold disaffirming belief systems. Legislation specifically protecting trans people from discrimination and violence is almost nonexistent. Whether by failing to provide necessary protection or allowing legislation to pass that negatively impacts queer and trans people, political systems commit institutional betrayal and violation of queer and trans people's human rights (Smith & Freyd, 2013). As these political disparities become more apparent, opportunities to enact change that supports queer and trans people also will become more apparent and important. This public debate has the potential to support queer and trans people and re-traumatize them as the validity of their existence is debated in public (Levitt et al., 2009).

Queer and trans people also experience relational trauma at the sociopolitical level within personal relationships and from political entities. Queer and trans people may experience betrayal and damage to personal relationships from the potential harm of political policies being downplayed by family, friends, and communities (Drabble et al., 2018). Queer and trans people also experience a systematic lack of policies that protect their rights, relative to majority groups and communities (Flores et al., 2015). This experience has become more salient as potentially harmful policies targeted at limiting the rights of all marginalized individuals and communities emerged under the Trump administration (Drabble et al., 2018; Koski et al., 2019). In addition to targeted policies, the Trump administration did not take a proactive stance to defend queer and trans people when hate crimes were committed against queer and trans people in his name (Koski et al., 2019). However, on his second day in office, President Biden issued an "Executive Order on Preventing and Combating Discrimination on

President Biden issued an “Executive Order on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation,” which serves to roll back the persistent attacks of the previous administration on queer and trans people (American Civil Liberties Union, 2021).

At the sociopolitical level, “marginalized communities may feel that the political norms, institutions, and conventions on which they are dependent for protections have betrayed them” (Drabble et al., 2018, p. 497). Experiencing repeated and prolonged betrayal can cause queer and trans individuals to feel powerless (Flores et al., 2015). Even in experiencing powerlessness and betrayal, queer and trans people have demonstrated resilience and resistance to fight back against harmful policies that attempt to limit or completely take away their rights; however, the battle against these policies is traumatic (Levitt et al., 2009). This can occur in personal relationships with family or friends or through action taken at a broader level to affect change. Existing in a time when the legitimacy of one’s existence is repeatedly a topic of public debate (Levitt et al., 2009) is a form of relational trauma, and the fight against these policies can be further traumatizing. At the sociopolitical level, such policies can cause psychological turmoil among queer and trans people, as they fear that legal progress cannot be made without direct involvement from queer and trans people who are marginalized and devalued by the same society they wish to change (Levitt et al., 2009). Engaging in a constant battle against legal and political entities for the right to exist can result in continued experiences of relational trauma and withdrawing from fighting can result in continued oppression and discrimination (Levitt et al., 2009).

CLINICAL AND COUNSELING IMPLICATIONS

Increased Mental Health Challenges

An array of existential assaults on queer and trans people was presented in the previous text. Navigation of these multiple complex layers of traumas, conflicts, and stressors has been found to correlate with negative outcomes for persons with marginalized identities; one of the major impacts of experiencing high minority stress is a higher prevalence of mental health concerns. Minority stress posits that the prejudice and stigma experienced by AGM individuals creates unique and chronic stressors; therefore, these stressors are correlated with adverse physical and mental health concerns (Meyer & Frost, 2013 as cited in Meyer, 2015; Parent et al., 2019). In addition to the overall adverse mental health concerns, experiences of minority stress among AGM individuals have been correlated with internalized negative self-esteem (Herek et al., 2009), experiences of interpersonal trauma (IPT; Stenersen et al., 2019), and internalized homophobia and transphobia (King et al., 2008; Meyer, 2015).

Research with LGBTQ adolescents demonstrates increased risks and rates of substance use (Kann et al., 2016; Marshal et al., 2008), as well as suicidal thoughts and behaviors (Marshal et al., 2011; S. T. Russell & Joyner, 2001). LGBTQ adults and aging adults also have reported significant mental health disparities when compared to heterosexual and cisgender individuals including increased depression, substance use, and suicidal attempts (Cochran et al., 2003; King et al., 2008; Meyer, 2003). Much of the literature on the discrepancy in mental health concerns, when compared to heterosexual and cisgender individuals, centers on the prevalence of stigmatization, prejudice, and discrimination as contributors to the negative lived experiences of LGBTQ individuals and the subsequent development of these negative health outcomes (Herek, 2009; Meyer, 2003; Pachankis, 2007). The clinical vignette that is presented in Box 18.1 illustrates some of the mental health issues discussed in this section.

BOX 18.1

Clinical Vignette: The Case of Jessica

Jessica, a 34-year-old Latinx female, presented to counseling with mild levels of anxiety and depression. She is an artist and an art educator. She reported that she was struggling with how to have a relationship with her family who were devout Catholics. She reported

how to have a relationship with her family, who were devout Catholics. She reported growing up in that religious context had been very difficult. She was unaware of her queerness until she was older because there were so many negative messages about sexuality, about being a woman, and about being different—outside of the highly controlled identities within her church. She went to a religious primary and secondary school and was sent to college at a religious-based university. There she began to question her beliefs and her identity. Now as an adult, she has rejected the beliefs of her parents, but struggles with “finding her voice” and not “becoming invisible” when she is around them for visits. She also discloses that she was sexually abused as a child from someone within the church community.

Within sessions, she presents as intelligent, insightful, and motivated to heal from these experiences. She reports that she avoids religion and religious discussions whenever possible, becomes anxious and dreads the visits with her family, and when they inevitably want to pray with her or have an impromptu “Bible Study,” she withdraws, cries, and feels like she will “crawl out of her skin.” After these experiences, she reports that she feels “fuzzy” and disconnected from everyone; in response, she says she usually goes to sleep and may feel better the next day. She reports having distressing memories and dreams of being in church and being highly controlled. She also reports feeling similarly when hearing news reports about legislation, hate crimes against LGBTQ people, attacks against women, suppression of feminists, and the political divide, which is often fueled by religious differences.

Case Questions

1. What are your own feelings, biases, thoughts, and assumptions when hearing Jessica’s story?
2. Identify the complex layers of trauma for Jessica’s past and current situation. What types of trauma has Jessica directly or indirectly experienced?
3. How might you approach creating a safe, trauma-informed, and affirming space for Jessica?

Increased mental health concerns among AGM individuals are associated with stigma-related stress, including expectations of rejection and fear of victimization (Meyer, 2003; Pachankis & Branstrom, 2018). These stressors have been shown to emerge early in development and correspond with subsequent social isolation and psychological distress (Hatzenbuehler, 2009; Hatzenbuehler et al., 2008). As a result of these stressors, many AGM individuals feel forced to conceal their identities in social and workplace environments, which consistently has been shown to have detrimental effects on the identity development and well-being of AGM persons (A. Bryan & Mayock, 2017; Chung et al., 2009; Meyer, 2003; Pachankis, 2007). As such, AGM individuals and communities are at a greater risk of experiencing mental health disparities due to their lived experiences. Therefore, it is incumbent on clinicians to consider the experiences of their AGM-identified clients when considering clinical practices such as diagnosis, which may further perpetuate experiences of minority stress.

Diagnostic Issues

Although there are DSM-5 limitations in diagnosing “little t” trauma, the *International Classification of Diseases* (ICD-11; World Health Organization, 2018) offers a “sibling” diagnosis to PTSD, that of Complex PTSD (C-PTSD). Complex trauma events are defined as prolonged and repeated, as well as interpersonal in nature. As noted earlier regarding interpersonal traumas, complex trauma previously was regarded as exclusively occurring in childhood and/or perpetrated by one’s caregiver(s). However, it is now recognized as being able to occur exclusively in adulthood, and also in noncaregiver relationships (e.g., IPV). The original concept of complex trauma described situations in which the victim was held emotionally or physically captive (Herman, 2001). The authors argue that the common experiences of AGM-identifying individuals feeling constrained in their identity expression

complex trauma. In addition to the classic PTSD symptoms of intrusion, arousal, and avoidance, C-PTSD has three additional symptoms: **a**ffect regulation difficulties, **i**ntity issues in regard to having a poor sense of self, and **r**elational impairment. These symptoms, which can be remembered as **AIR**, reflect the interpersonal and relational nature of complex traumatization. Given that the AGM community is disproportionately exposed to physical and sexual violence in adulthood, childhood sexual and physical abuse, IPV, and hate crimes, it is often the case that they likely meet criteria for complex trauma as well as trauma events as typically defined in the *DSM-5*.

Beyond traumatic symptomatology, research finds that AGM individuals have higher rates of other mental health problems (e.g., depression, anxiety, substance abuse or misuse) as compared to cisgender and heterosexual individuals (Dhejne et al., 2016; Semlyen et al., 2016). In fact, of those diagnosed with PTSD, 80% have a comorbid diagnosis (Kessler et al., 1995).

Often, depression and anxiety are comorbid with PTSD. Depression and anxiety may precede and increase risk for developing PTSD, may share an overlap in symptoms, or may be secondary or symptomatic responses to traumatization (Ginzburg et al., 2010). In this case, resolving the trauma also would mitigate the comorbid symptoms. However, in individuals with prolonged and repeated abuse or traumatization, the depression and anxiety, although secondary, can be debilitating and may be the primary presenting concern. Understanding and conceptualizing this would be important in determining the best course of treatment, often focusing on safety and stabilization of the depression and anxiety first, and then focusing on resolving the trauma.

Additional diagnoses may be forms of coping with societal stigmatization, hate and prejudice, and other traumas. For example, alcohol and substance abuse may be used as a form of numbing or coping with fear-based and/or depressive and anxious emotions (Parent et al., 2019; Reisner et al., 2015; Weber, 2008). Substances also may be used to aid in sexual intimacy to “dissociate” from intrusive reminders of past sexual violations (Pantalone et al., 2017).

Diagnosis of personality disorders may be more prevalent as well. Indeed, discerning among PTSD, C-PTSD, and borderline personality disorder (BPD) can be challenging. Symptoms of affective instability, poor self-concept, and interpersonal difficulties are hallmark symptoms of BPD. They are also the core features (AIR) of C-PTSD. Cloitre et al. (2014) created profile analyses to compare and contrast the three conditions. In the C-PTSD group, they were significantly more likely to endorse nightmares and avoidance of thoughts, as compared to BPD. Further, for those with BPD and compared against C-PTSD, they endorsed more frantic efforts in relationships, unstable relationships, an unstable sense of self, impulsiveness, self-harm, mood changes, temper, and paranoia/dissociation.

Another discerning factor would be chronology. By definition, C-PTSD arises as a result of trauma events; therefore, gathering a timeline of trauma events and their correspondence with various symptoms would be necessary. Less helpful in diagnosis, but also an indicator, is that a hallmark feature of personality disorders is chronicity; if after treatment the symptoms of disturbances in affect, identity, and relationships remit, then it would be accurate to say that the diagnosis was C-PTSD.

Trauma-Informed and Trauma-Focused Interventions for Queer and Trans People

Trauma-Informed Affirmative Care as an Approach and Style

Research remains somewhat mixed on the treatment-seeking behaviors within this population. For example, research supports the notion that affectional minorities are more likely to seek out services from a mental health clinician (Cochran et al., 2003). More specifically, Cochran et al. (2003) found that more than half of gay and bisexual men and more than 60% of lesbian and bisexual women visited a mental health clinician, saw a medical doctor for an emotional concern, attended a self-help group, or took psychotropic

medical doctor for an emotional concern, attended a self-help group, or took psychotropic medication in the previous 12 months. As a comparison, only 25% of heterosexual men and almost 36% of heterosexual women reported engaging in those services (Cochran et al., 2003). This also has been replicated more recently: nonheterosexual individuals were two to four times more likely to see a mental health clinician as compared to heterosexual individuals (Platt et al., 2018). However, the methodology of these studies is often problematic in that it defines "treatment utilization" as attending one or more visits. That is, someone who engages for 30 visits to a therapist or counselor would be coded as just as engaged as someone who visits a clinician one time and then "drops out" of treatment. Thus, a more accurate term might be initiation of services. Additionally, the extant literature does not focus or address trans and gender expansive individuals. It is more than likely that these results generalize to gender minorities, given that this community faces additional biases from clinicians and staff within a counseling and medical context (Stotzer et al., 2013). Micro- and macro-aggressions such as using incorrect pronouns, inadequate or lacking knowledge of differences between biology and identity, and discomfort in talking about sexual health and well-being may all lead to disengagement, or dropping out, of therapeutic care.

In fact, while AGM individuals may initiate treatment at higher rates than their heterosexual counterparts, they also report greater dissatisfaction in their clinicians, usually due to lack of clinicians' cultural competence in working within this community (Hudson-Sharp & Metcalf, 2016). Compounding this is a lack of clinicians who are trained in trauma-informed therapy (see Cook et al., 2017) and subsequently lack the necessary competencies to deliver trauma-informed and trauma-focused interventions.

Affirmative care and trauma-informed care share many overlapping similarities, to the point where one could argue that affirmative care *is* trauma-informed care. In fact, affirmative trauma-informed care can contribute to posttraumatic growth, a sense of growth that comes from challenging one's beliefs and facing a psychological struggle (Calhoun & Tedeschi, 2006). Both styles are approaches of interacting with clients from a strengths-based perspective, with a focus on client empowerment and resilience. The two models emphasize the responsibility of the clinician to acknowledge, confront, and continuously revise one's biases and assumptions. In affirmative care, therapist biases might include what it means to be AGM and who is really a part of the community; in trauma-informed care, therapist biases may be present in regard to believing that only certain genders can be traumatized or assuming disorders of personality when presented with relational disruptions. Treatment goals are established collaboratively, with an intention to reduce hierarchical and authoritarian experiences in the context of the therapeutic relationship. Further, affirmative trauma-informed care requires the tailoring of evidence-based interventions based on clients' intersecting identities and experiences, and a focus on developing and enhancing skills to navigate various domains within society. For an overview of trauma-based competencies, see Cook et al. (2014).

Given the prolonged and repeated nature of trauma facing queer and trans people, and the presence of additional traumatic experiences that may not be considered at a diagnostic threshold, Herman's (1992) three-phase model also should be considered. The model emphasizes the need to build a trauma-informed, secure and trusting, affirmative relationship prior to any trauma-focused work. In the first phase, building rapport within a strong therapeutic foundation is emphasized. This stage also emphasizes the need to build up coping skills, which can be used in lieu of maladaptive skills. To prevent regression in treatment when beginning the challenging work of trauma processing, clients need emotion regulation and distress tolerance skills. Then, in phase 2, they are able to begin the emotionally difficult task of processing and resolving their trauma by employing their new skillset. In the third phase, the focus is on reintegration, in which the individual learns how to live their best life in social, occupational, relational, and intrapersonal domains. The benefit of such a model is that it does not immediately focus on trauma, which can be destabilizing. Rather, it focuses on skill development and the here-and-now, which can consist of issues such as unemployment, homelessness, and familial and/or spiritual rejection, among others. By focusing on present-day issues to create a safer system, as well as teaching affect regulation and distress tolerance skills, this leaves space for eventual trauma processing through formal

and distress tolerance skills, and leaves space for eventual trauma processing through formal evidence-based trauma exposures or nonmanualized narrative forms.

Evidence-Based Trauma Interventions

Trauma-focused care refers to the evidence-based interventions specifically targeting PTSD symptoms. The APA (2017) developed PTSD Treatment Guidelines based on a systematic review of empirical studies evaluating psychotherapy outcomes. Cognitive-behavioral therapy, prolonged exposure (PE), and cognitive processing therapy (CPT) emerged as robust interventions with large effect sizes in reducing trauma symptoms. It should be noted, however, that the experimental studies selected for inclusion did not include AGM populations and likely require tailoring (Livingston et al., 2019). Both PE and CPT involve some form of exposure-based exercise. In PE, the goal is to practice both imaginal and in vivo exposures; in CPT, the goal is to challenge cognitive distortions that emerge after writing a detailed narrative of the traumatic event. In sum, these treatments are effective for a Criterion A event and Criteria B to E symptoms. An additional consideration is that these are treatments for *post*traumatic stress. These would not be effective when considering that many AGM individuals may be presenting to treatment with current traumatization (e.g., IPV, risk for assault and hate crimes, trafficking, or exploitation).

Evidence-based treatments for trauma, as is, may not be appropriately tailored to the AGM community. As an example, consider CPT that focuses on breaking and replacing “stuck points,” or maladaptive thoughts. A common stuck point includes, “I cannot keep myself safe,” with the intended goal of having the individual reframe this to, “I may not be able to keep myself safe in all situations.” Taken at face value, this may be insensitive to the real threat of outside violence. Therefore, a key recommendation is to apply a stigma-informed approach (G. M. Russell & Hawkey, 2017), in which the clinician acknowledges the proclivity to blame oneself and disproportionately accept responsibility and move to one of externalizing and understanding occurrences in the context of a larger macrosystem.

SOCIAL JUSTICE AND ADVOCACY ACTIONS

Though a common theme throughout the research literature has indicated that queer and trans individuals experience higher rates or are at an increased risk of mental health concerns when compared to heterosexual and cisgender-identified individuals, it is important to consider that these studies often are framed as correlational, with outcomes based on identities of the individuals rather than examining the systems and social/cultural milieu which oppresses and marginalizes these identities (A. Bryan & Mayock, 2017). In addition to considering appropriate and ethical clinical responses with this population, counselors and related mental health professionals also need to understand and act within their role as a social justice advocate to address the oppressive systems that cause and perpetuate this trauma (American Counseling Association, 2014; Ratts et al., 2010, 2015).

At the individual level, mental health professionals should investigate their lived privilege and biases when working with this population (Ratts et al., 2015). Likewise, mental health professionals need to do their own work in investigating their internalized and oppressive beliefs regarding gender and affectional variance (Singh, 2016). In what ways might a hidden bias or privileged viewpoint injure the client? For example, a counselor may behave in a microaggressive manner to a client, which could lead to cessation of counseling, increase mistrust of counselors, and increase their experience of trauma. A counselor may evidence discomfort in their body language surrounding the experiences a queer client is discussing, may use outdated or problematic terminology (e.g., use the term “homosexual” which is an outdated and stigmatized term that is no longer used), or express heteronormative assumptions about a client. It is incumbent on mental health professionals and educators to incorporate supervision and training that is aimed at addressing these oppressive systems, rather than minimizing or dismissing one’s lived experiences as an LGBTQ individual (S. Bryan, 2018).

Using a liberation framework, therapists should provide psychoeducation and a trauma-informed space to allow clients to empower themselves (Ratts et al., 2010). When the client

provided space to allow clients to empower themselves (Ratts et al., 2010). When the client faces barriers within the systems they are navigating, counselors should collaborate with and work on behalf of the client to assist in planning and implementing a plan of action to counter barriers and find resources (Ratts et al., 2010). For example, counselors could take a feminist approach and encourage a liberation dialogue by discussing the role of the oppressive culture; dialoguing with clients on what has been taken away from them through the process of growing up in a heterosexist and cissexist culture can be liberating and healing (Richmond et al., 2017; Singh, 2016). Counselors could provide psychoeducation that queer and trans persons were important figures in indigenous cultures, seen as inherently valuable and spiritual; exploring how society and colonization have changed positive perceptions to ones that are oppressive for LGBTQ people and other marginalized people may be helpful for clients (Singh, 2016). Additionally, counselors also should explore the ways that clients resist these oppressive and traumatic experiences; their resilience and survival are strength-based themes, which can be helpful to explore in an effort to assist clients to self-empower (Singh, 2016).

At the community level, mental health professionals should serve as a support for the queer and trans communities in fighting systemic barriers that they face (Ratts et al., 2010). Counselors should stay connected to advocacy organizations like the Human Rights Campaign and the Society for Sexual, Affectional, Intersex, and Gender Expansive Identities to remain knowledgeable about issues facing these populations, develop alliances with community members and stakeholders, and educate other important stakeholders in community centers and schools. For example, a therapist could advocate to have a speaker from this population come to a clinical mental health agency to offer professional development, review their site's trauma-informed practices, and assess the LGBTQ-affirming practices of the agency. Ensuring that there is an affirming counseling space, appropriate language on forms, and quality, well-trained staff is important in creating a context in which healing can occur for these populations.

Finally, at a social and political level, mental health professionals can find ways for members of the community to have their voices heard about the issues that impact these populations, as well as combat practices that perpetuate cissexism and heterosexism and lead to further experiences of trauma (Ratts et al., 2010). Some of these issues include advocating for better law enforcement training around issues of diversity, including sexual and gender identity, to increase awareness and responsiveness to hate crimes (Human Rights Campaign, 2018). Additionally, mental health professionals can advocate for increased research and advocacy for trans populations, as these communities are experiencing more frequent and more violent attacks than LGB communities (Clements-Nolle et al., 2006). Finally, counselors can advocate for state and national protection for all queer and trans people from discrimination in any context (Burgess et al., 2007).

CONCLUSION

Despite improving acceptance in the culture, queer and trans people continue to face adversity, marginalization, and trauma that impact them at a holistic level: mind, body, and spirit. Who they are, at a core level, can be denigrated; they may experience stressors and trauma at an interpersonal level, within their peer groups, families, communities, faith systems, and work. They also may face continued political and social marginalization, invalidating their humanity and access to human rights. As helping professionals, we are challenged to investigate our own internalized oppressive beliefs and experiences surrounding gender and queerness; provide a safe, trauma-informed, and affirming space for all clients; and promote healing, liberation, and self-empowerment with LGBTQ clients through the use of affirmative and trauma-informed practices.

ADDITIONAL RESOURCES

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