extra

Journal of Mental Health Counseling
Volume 30/Number 2/April 2008/Pages 121–136

Transgenerational Trauma and Resilience: Improving Mental Health Counseling for Survivors of Hurricane Katrina

Rachael D. Goodman
Cirecie A. West-Olatunji

As disasters increase worldwide, there is greater need for effective and expedient disaster mental health response. The purpose of this paper is to present the etiology of transgenerational trauma to advance mental health counselors' understanding of the complex issues associated with trauma and disaster. The authors have woven literature from the field of trauma counseling with their own clinical experiences during deployment in post-Katrina New Orleans. The authors assert that mental health counselors can enhance clinical practice by using transgenerational trauma assessment and interventions as well as historical and contextual knowledge. A case example and recommendations are provided to demonstrate how to incorporate transgenerational trauma and resilience into clinical practice when working with disaster survivors.

In the aftermath of Hurricane Katrina, there was an unprecedented presentation of mental health issues that are anticipated to have long-term effects over the next decade or more (T. Iliff, personal communication, June 8, 2007). Counselors competent in disaster response are needed to provide expedient services to affected communities (Rogers, 2007). Globally, the need for mental health disaster relief services is rising due to the increase in natural and human-made disasters (Guha-Sapir, Hargitt & Hoyois, 2004; U.S. Committee for Refugees and Immigrants [USCRI], 2006; Walter, 2005). Aggravating this phenomenon is the underlying concern that mental health counselors often fail to address transgenerational trauma (Danieli, 1998). This issue is particularly critical for socially marginalized clients (Burstow, 2003; Cross, 1998). We employ resilience theory as a lens for presentation of this issue as it allows clinicians to take into account client-defined risk and protective factors (Waller, 2001; Walsh, 2002). These factors are often ignored in traditional trauma counseling literature. The purpose of this paper is to introduce transgenerational trauma as

Rachael D. Goodman and Cirecie A. West-Olatunji are affiliated with the Department of Counselor Education at the University of Florida. Correspondence regarding this article can be addressed to Rachael D. Goodman at the College of Education, University of Florida, 1204 Norman Hall, POBox 117046, Gainesville, FL 32611. E-mail:rachaeldg@gmail.com.

an effective assessment and intervention approach for responding to disaster survivors. A case example from the disaster response activity in post-Katrina New Orleans is provided and five recommendations are offered to enhance disaster mental health counseling competence.

TRANSGENERATIONAL TRAUMA

Mental health counseling is often guided by the American Psychiatric Association's (APA), *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) (Eriksen & Kress, 2006; Mead, Hohenshil & Kusum, 1997; Seligman, 1999; White, 2002). Of particular interest to counselors providing post-disaster counseling is the influence of the diagnosis of posttraumatic stress disorder (PTSD), first included in the *DSM* in 1980. Indeed, creation of the PTSD diagnosis legitimized trauma as a psychological stressor and also defined the nature of trauma (Halpern & Tramontin, 2007; Scaer, 2001). Further, the PTSD diagnosis articulated expected effects of trauma (Rothschild, 2000; van der Kolk & McFarlane, 1996), informed mental health treatment (Becker, 1995; Danieli, 1998; Eriksen & Kress; Herman, 1997), and provided insurance coverage and legal recourse for those who experienced a traumatic event (Burstow, 2005; Cosgrove, 2005; James & Gilliland, 2005; McLaughlin, 2002; White).

However, the *DSM* provides a somewhat limited view of trauma in that the criteria consider only the direct experience of a psychically dangerous event to be traumatic (APA, 2000; Burstow, 2005; Danieli, 1998). Critics of the PTSD definition have noted the minimization of individual perception (Rothschild, 2000) and the exclusion of experiences that are common in certain communities (Levine, 1997), including patriarchal violence experienced by women (Burstow, 2003, 2005). The individualistic focus in the current definition excludes trauma that is situated within a larger context (Ivey & Ivey, 1998). Despite revisions in the *DSM*, significant limitations within the PTSD criteria persist (Burstow, 2003; Halpern & Tramontin, 2007). Specifically, the *DSM* definition excludes transgenerational trauma, or trauma that is passed down from one generation to another (Dass-Brailsford, 2007). This type of trauma occurs without direct traumatic stimulus but is instead transmitted from a parent who has experienced a traumatic event (Davidson & Mellor, 2001; Nagata, 1990). As such, transgenerational trauma is often overlooked by clinicians (Burstow, 2003; Danieli, 1998; Kira, 2001).

The concept of transgenerational trauma was developed primarily from the study of how Nazi Holocaust survivors' children were impacted by their parents' traumatic experiences (Danieli, 1998). The prevalence of mental health treatment for these children in the late 1960's sparked impact studies in Canada, the United States, and Israel. Investigations of transgenerational trauma have also included families of veterans from World War II and the Vietnam War

(Aarts, 1998; Bernstein, 1998; Rosenheck & Fontana, 1998a, 1998b), indigenous peoples (Duran, Duran, Yellow Horse Brave Heart & Yellow Horse-Davis, 1998; Raphael, Swan & Martinek, 1998), and survivors of domestic violence and child abuse (Gardner, 1999; Schechter, Brunelli, Cunningham, Brown & Baca, 2002; Simons & Johnson, 1998; Walker, 1999).

The internment of Japanese Americans during World War II, the enslavement of Africans, and genocidal acts against indigenous peoples are three poignant examples of transgenerational trauma in the United States (Dass-Brailsford, 2007). These historical events continue to impact the mental health of those descendents; significant mental health effects, such as depression, anxiety, hypervigilance, low self-esteem, suicidal ideation and behavior, substance abuse, violence, and loss of cultural identity have been cited (Dass-Brailsford; Duran et al., 1998; Felsen, 1998; Raphael et al., 1998; Simons & Johnson, 1998). It is within this context that scholars have advocated for culturally sensitive assessment (Dana, 1993; Ibrahim, Roysircar-Sodowsky & Ohimshi, 2001; Suzuki, Meller & Ponterotto, 1996).

Transgenerational Trauma in Post-Katrina New Orleans

A disaster is a human-caused or natural event that results in significant destruction and often the loss of life, and has a lasting impact on the environment and the community (Halpern & Tramontin, 2007). For the residents of New Orleans, previous experiences with disasters can lay the foundation for comorbidity: transgenerational trauma on top of disaster-related trauma symptoms.

In a 2001 article in *Scientific American,* Mark Fischetti called the city, "a disaster waiting to happen," in part due to its precarious position below sea-level and the continual loss of its buffering delta. Additionally, at multiple times in recent history, New Orleans has either been impacted or been threatened by natural disasters. Hurricane Betsy, hitting the city in 1965, flooded some parts of the city with eight feet of water and killed 65 people (Brinkley, 2006). Hurricanes Andrew and Georges, in 1992 and 1998 respectively, both narrowly missed the city. Furthermore, in 1927, city officials purposefully flooded parts of New Orleans by dynamiting a levee in order to save other parts of the city from damage due to the Great Mississippi Flood (Brinkley). The Lower Ninth Ward, a predominantly Black working class neighborhood, and St. Bernard parish, a blue collar White community, were the adjoining areas sacrificed, engendering mistrust in the city government. The devastation to these two communities is parallel despite the skewed media focus on the Lower Ninth Ward following Hurricane Katrina (Frazier, 2006).

In the aftermath of Hurricane Katrina, residents of New Orleans contend with high rates of unemployment, skyrocketing insurance costs, and increased housing costs (Greater New Orleans Community Data Center [GNOCDC]; 2007).

Even two years later, much of the infrastructure of New Orleans is still not functioning, including childcare facilities, public transportation, medical facilities, schools, libraries, and restaurants. Economic hardship and widespread displacement are also critical issues of the city.

Based upon current knowledge about post-disaster outcomes, it was expected that New Orleans residents (as well as responders and healthcare workers) would experience high rates of anxiety, depression, substance abuse, and PTSD (Weisler, Barbee & Townsend, 2006). The mental health concerns were further complicated by the displacement of residents that has been found to be a significant risk factor in the development of posttraumatic symptomology (DeSalvo et al., 2007). While caution is suggested in diagnosing PTSD (Galea, Nandi & Vlahov, 2005), there appears to be significant post-trauma symptoms among New Orleanians that can be psychologically disruptive. In fact, based upon a study conducted by the Centers for Disease Control and Prevention (2006), it was found that that over 50% of the residents reported severe health concerns without the availability of a healthcare responder. More importantly, residents reported varying levels of mental health needs, yet only 1.6% of those in need actually received services. Concerns about mortality, suicide, and violence were realized when, within the first six months following Hurricane Katrina, there was a 25% increase in mortality rates. Suicide rates had increased nearly threefold. Consistent with disaster response literature (Freedy & Simpson, 2007; World Health Organization, 2005), New Orleans residents are currently experiencing significantly higher rates of interpersonal violence with resultant higher mortality rates (Franks, 2007).

Transgenerational Resilience

While transgenerational trauma can generate latent trauma in future generations, it may also instill unique coping skills and resilience. Resilience theory states that individuals and families experience a dynamic process whereby they face challenges and also develop coping mechanisms that allow them to overcome these challenges (Walsh, 2002). Despite significant risk, resources from the individual, family, and community all contribute to the ability to overcome such obstacles (Echterling, Presbury & McKee, 2005). Risk factors for traumatic stress symptoms include lack of social support (Bonnano, 2004) and a history of mental illness (Bromet, Sonnega & Kesser, 1998). Furthermore women, childhood trauma survivors, and individuals with a family history of mental illness are also at higher risk for the development of traumatic stress symptoms (Breslau, 2002).

Protective factors are resources that can mediate the effects of a traumatic event and include factors such as a sense of cultural/racial identity (Tummala-Narra, 2007), a belief that life is meaningful (Bonnano, 2004), and family support (Spaccarelli & Kim, 1995). Furthermore, it is critical to include factors

such as client identity, socioeconomic status, and cultural mores when conceptualizing both risk and protective factors (Cross, 1998; Waller, 2001).

Mental health professionals can use resilience to focus on strengths of an individual or group and promote healthy functioning despite adversity (Halpern & Tramontin, 2007). Resilience theory is particularly appropriate for New Orleans residents as it includes transgenerational factors (Walsh, 2002), individual and family factors (Waller, 2001), and relevant historical and cultural factors (Hsu, Davies & Hansen, 2004). Furthermore, resilience theory incorporates the individual's perspective into an understanding of both stressors and strengths, allowing the clinician to develop an accurate conceptualization of that individual's particular resilience factors (Walsh). Thus, resilience theory provides a useful lens for consideration when counseling disaster-affected clients who present transgenerational symptomology. Considering transgenerational trauma and resilience, an ecosystemic framework allows for the integration of contextual risk and protective factors. Recent scholarship in trauma counseling has indicated a trend towards incorporating an ecosystemic approach that attends to contextual factors (Harvey et al., 2003; Harvey & Tummala-Narra, 2007; Harvey, 2007; Hughes, Humphrey & Weaver, 2005; Kira, 2001).

Use of a case example to illustrate the clinical application of mental health service delivery has been effective in presenting complex issues (Calley, 2007; Costa, Nelson, Rudes & Guterman, 2007; Hooper, 2007).The case example presented below provides an example of how transgenerational trauma and resilience can be used to effectively assess and intervene with a survivor of natural disaster. This is a composite case example based upon our deployments where we provided mental health disaster services in New Orleans.

CASE EXAMPLE

"Arthur" is a divorced, 41-year-old White, male managerial employee at a downtown, locally-owned hotel who lives alone. Prior to Hurricane Katrina, Arthur lived in his single-family dwelling home in a middle-class neighborhood in New Orleans. Approximately 30 days after Hurricane Katrina swept the city, a mental health counselor was contracted by a local hotel to provide mental health disaster services to the staff and guests on a part-time basis, two to three days per week. Clinical services, such as individual counseling, single session brief counseling, crisis intervention, assessment and referral, and group counseling, were provided. Within two months, that counselor, a New Orleans native, was no longer able to provide services, due to burnout and vicarious stress, and referred the contract to another local mental health counselor who continued to provide similar services. That counselor also experienced vicarious stress and discontinued services after three months of service provision.

One year following Hurricane Katrina, one of us (C. West-Olatunji), a professional counselor, counselor educator, and a former New Orleanian was contacted by the hotel administration to provide follow-up clinical services. The counselor educator, along with two other counselors worked on-site at the hotel for seven consecutive days, providing individual and group sessions, as well as informal outreach. Services provided included informal meetings and clinical sessions with hotel staff to: (a) rescreen for trauma reactions, (b) assess for improved coping skills as well as knowledge of and access to services, and (c) provide referrals (Collins & Collins, 2005). Additional follow-up visits have occurred approximately every six months since the initial outreach by the counselor educator.

Although Arthur had never been to counseling, he seemed interested in sharing his story about the loss of material possessions and the privacy of his home. In group counseling sessions, Arthur initially appeared hesitant about disclosing his feelings. However, in session, Arthur was able to express his sense of being overwhelmed by the task of rebuilding and the loss associated with the destruction of his neighborhood community. He stated, "I have to sit to take a shower, and my feet hang off the end of my bed in my FEMA [Federal Emergency Management Administration] trailer but I don't care because that trailer gives me my independence back." Additionally, Arthur talked about the challenges at work and the extended hours without relief due to the shortage of workers.

Arthur articulated what seemed to be his frustration with how the effects of Hurricane Katrina have been portrayed in the media. He shared his perceptions of the media as marginalizing the people in the Gulf Coast region in general but New Orleanians in particular. He expressed anger as he spoke of the news reports that portrayed the city residents as solely impoverished individuals on welfare. He described his neighborhood as a multiethnic array of professional, middle-class people. Arthur spoke of the large numbers of residents that were either without a home or whose home could not be repaired due to the shortage of building contractors. He felt that the media needed to address the day-to-day concerns of New Orleanians, such as exposing social injustices perpetrated by insurance, rental, and utility companies. Arthur's anger may have reflected his reaction to an unresponsive system in which the needs of the disaster survivors were not being met.

In the group, other participants talked about the unusually high bills that they were receiving from their power companies for the months when they were unable to inhabit their homes. Participants reported that insurance companies had provided unfair estimates of property values or refused to cover residents under obscure contract clauses. Arthur expressed concern over the inflated apartment rental costs that make it prohibitive for most New Orleans residents to return to the city. The counselor noted his indignation for his fellow residents

despite the fact that Arthur had secured a FEMA trailer and this was not a personal concern.

Arthur talked about the recovery during the aftermath of Hurricane Betsy when his family learned of the intentional flooding of his working class neighborhood in St. Bernard parish. As part of the group exercise, Arthur shared his family narrative about how they survived Hurricane Betsy. Though he had not been born when Hurricane Betsy hit New Orleans, he could vividly recount his father's story. He stated that, during family gatherings, such as holidays and cookouts, his father would often recite the following story:

> *I remember being stranded on the rooftop of our home with my wife and children. We could see some of our neighbors on top of their rooftops as well. We hadn't eaten for some time and my children were tired, hungry, and frightened. I didn't know where my parents were or even if they were alive. We saw bodies floating in the water, lots of bodies floating by our rooftop. I couldn't protect my children from this ghastly scene. All we could do is hope for rescue or, at the very least, food and water dropped from helicopters until help arrived. Eventually, rescue workers came in canoes and took us to the Domino sugar factory down the river. We were there with hundreds of other families, packed into warehouses like the sardines in a can that we ate for weeks on end. There was no privacy; all of our possessions were gone. We didn't yet know the status of other family members. And, we commiserated with each other by sharing stories of our survival and losses. One thing we knew for sure, it was that the government had failed us. We were expendable for the sake of money and big business. The hard working residents in lower middle-class communities in St. Bernard were sacrificed in the name of commerce and profitability. That resonated for us. We would rebuild because we could not leave the land where seven generations of our family lived and died but we would never trust the government again.*

Arthur expressed that he was intimately aware of the social injustice in disaster response and believed that recovery would be up to individuals without sufficient support from the federal or local government agencies. He also disclosed that, as a child, he suffered from nightmares and mild anxiety during heavy storms. Additionally, he experienced severe asthma attacks until the age of 14.

Arthur also talked about the lack of understanding from outsiders who constantly asked why the people of New Orleans didn't evacuate when they knew the storm was coming. He shared how New Orleans residents have survived storms and false forecasts of dangerous hurricanes for over 40 years. Ever being warned that, "the big one is coming," and to evacuate, Arthur shared that New Orleanians had survived Hurricanes Ivan and Betsy, and they really had no interest in leaving this time. Most importantly, Arthur believed that this was a human-made disaster, rather than a natural disaster. They had survived the hurricane but not the breaking of the levees. He stated that the levees were made by man and neglected by man. While he expressed some resentment, he also demonstrated resignation and commitment to the necessary recovery tasks.

Areas of concern in assessing Arthur's case focused on his lifestyle and social

support. He reported that his parents and siblings had relocated outside of the area and did not plan to return. Additionally, Arthur lived alone and most of his social networks were associated with his job. Given that the people at his job were in similar circumstances, the counselor paid close attention to the coping skills evidenced within his social support network. Investigation revealed that his closest associates were also Hurricane Betsy survivors who shared his conviction that his recovery, as well as that of the city, was conceivable. Follow up visits with Arthur at his workplace confirmed this initial assessment. Arthur and his coworkers have formed informal recovery teams wherein they spend their days off helping each other with construction projects at each other's homes. In the most recent session with Arthur, he emphasized how his job served as a haven for him and the other employees to help them regain a sense of normalcy following the aftermath of the storm.

In the case presented, Arthur began his journey following Hurricane Katrina with a belief that he could restore his home and his sense of safety. He began with a strong support network that generated from his work environment. Additionally, he plunged himself into his work as a way to funnel his energies and reduce his sense of feeling overwhelmed by the tasks at hand. As time wore on, and the federal support failed to materialize, he became more despondent and began to separate himself from his colleagues at work. A normally gregarious person, Arthur was less engaged socially and retreated to his FEMA trailer. In working with Arthur, the counselor used interventions that encouraged him to recall childhood memories about how his parents recovered from Hurricane Betsy. During the sessions, Arthur was able to capture his parents' resilient attitudes and behaviors and was able to reflect on ways in which he could replicate those coping mechanisms.

As a result of the group experience, Arthur invited members of the group (including the counselor) to view the progress on his home. During the visit, Arthur appeared more animated, engaged, and talkative as he provided a tour of the damage to his home and shared his plans for restoring the house for reentry. He also talked about his parents' ability to rebuild the family home following Hurricane Betsy. The reflexivity between his parents' survival of Hurricane Betsy and his ability to recover from Hurricane Katrina was evident.

IMPLICATIONS

Given our current knowledge about the impact of traumatic experiences on subsequent generations, it is necessary for mental health counselors to become educated about the significance of historical and contextual factors in case conceptualization (Burstow, 2003; Cross, 1998; Danieli, 1998). Moreover, contemporary disaster-related events suggest that mental health professionals must pay more attention to intergenerational influences when working with disaster

survivors. With this knowledge, counselors can reduce misdiagnosis while considering differential and dual diagnoses. When counselors fail to incorporate factors, such as client identity, socioeconomic status, and cultural mores, they foster a limited view of clients' strengths and barriers to functioning (Cross; Waller, 2001). An individual's identity, whether related to gender, age, sexual orientation, geographical location, or vocation, influences her or his perception of available choices (Halpern & Tramontin, 2007). Without the necessary supports, clients' ability to demonstrate resilience can erode over time. Moreover, without adequate skills, mental health counselors can potentially aggravate any pre-existing stress experienced by disaster survivors when there is the presence of transgenerational trauma.

Counselors can effectively utilize clients' personal resources by exploring those childhood memories that relate to presenting problems. Use of narrative tools that foster client disclosure may be helpful in illuminating protective and risk factors associated with transgenerational trauma and resilience. Such tools might include facilitating the client in story-telling about the trauma, accessing elements of the trauma story that were previously unknown, and empowering the client to re-story (Duvall & Beres, 2007). Central to this idea is the counselor's ability to partner and collaborate with the client in co-constructing a new narrative that incorporates resiliency. Building on the client's historically embedded personal strengths can foster expediency.

The concept of expediency plays an important role in disaster response as it contributes to a reduction of the posttraumatic stress experienced following a disaster (Halpern & Tramontin, 2007; Rogers, 2007). This is critical to the restoration of normalcy for individuals, families, neighborhoods, and the affected region as a whole. One intervention used by the counselors who worked with Arthur was the Story Circle exercise (Williams-Clay, West-Olatunji & Cooley, 2001). The protocols of this particular intervention encourage participants to share their stories based on the thematic link to the previously shared narrative by a group member. Those who have higher levels of functioning can assist individuals who exhibit less resilience. As such, the participants weave a web of related stories and create synergy through shared knowledge. This technique addresses issues of transgenerational trauma in that the collective historical experience is shared, analyzed, and then used to construct solutions by the group members as a unit.

Five Suggestions for Improved Practice

The case example presented provides an illustration of how one individual accessed childhood memories that reflected resiliency based on his knowledge of his parents' response to Hurricane Betsy. Conversely, other survivors of Hurricane Katrina may present more persistent intergenerational trauma symptoms, such as depression, anxiety, and suicidal ideation (Weisler et al., 2006).

Suggestions for enhancing effectiveness when responding to disaster-affected individuals with transgenerational symptomology include appropriate assessment, education, conceptualization, empowerment, and intervention strategies. Five recommendations for incorporating transgenerational trauma into disaster mental health response are noted below.

Recommendation One: Assess for transgenerational trauma. Traditional trauma assessments rely on the *DSM-IV-TR* in order to assess for trauma, thus excluding transgenerational trauma (Burstow, 2003; Danieli, 1998). Given its potentially significant effects (Duran et al., 1998; Felsen, 1998; Raphael et al., 1998; Simons & Johnson, 1998), it is critical that mental health counselors augment traditional trauma assessments to include transgenerational trauma. Obtaining histo-personal information from a client that includes family trauma history alerts the clinician to the possibility of transgenerational trauma. This information can be garnered during the intake or initial counseling session in order to include transgenerational trauma as a possible component of case conceptualization.

For clients who are at risk for transgenerational trauma, the clinician can then assess for any posttraumatic stress disorder symptoms related to the prior historical traumatic event, such as flashbacks or hypervigilance (APA, 2000). This can be explored during the beginning phase of treatment as a way of increasing the client's awareness of his or her experiences of transgenerational trauma and resilience, as well as processing salient risk factors or traumatic experiences and building on protective factors. Some of the probes that may be particularly effective include the following:

- Is there a family history of trauma?
- What were some of the traumatic symptoms your parents exhibited?
- Have you experienced any similar symptoms?
- Do you have any children? If so, have you observed any of those symptoms among your children?
- How did your parents respond to their traumatic symptoms?
- Were your parents ever treated for their symptoms?
- Can you tell me how your parents were able to recover from the previous trauma?
- What resources were available to them?
- What coping skills did you learn from your parents?

One instrument that can be useful in the assessment of transgenerational trauma includes the color-coded timeline trauma genogram, which helps identify transgenerational sources of trauma and allows for processing these events (Jordan, 2004). The Multidimensional Trauma Recovery and Resiliency Scale can also be used to assess the client's post-trauma symptoms, development of

meaning, and coping skills (Harvey et al., 2007). Future research in this area might focus on additional instrument development in order to provide clinicians with a norm-referenced interview protocols and a diagnostic and intervention tool with this population. Assessments that catalogue data from multiple generations can inform clinical practice with disaster-affected individuals and communities. Additionally, little is known about culturally specific disaster responses of ethnocultural populations. Clinical researchers need to explore how culturally sensitive assessment tools might better access the nuanced coping skills as well as vulnerabilities of culturally diverse communities (Dana, 1993; Ibrahim et al., 2001; Suzuki et al., 1996).

Recommendation Two: Obtain education about the histo-personal context. Transgenerational trauma is directly linked with past exposure to trauma within the family (Danieli, 1998). Thus, clinicians can prepare themselves to work with clients by being aware of the historical and sociopolitical issues that may have directly impacted a family and indirectly influenced the client. Prior knowledge about a client's histo-personal context can alert the clinician to potential transgenerational trauma and can therefore allow the clinician to assess for and intervene with the client around these issues more expeditiously.

Community stakeholders can provide a wealth of information about the history and sociopolitical context of the neighborhoods from which clients originate. Starting with existing connections to community agencies or educational institutions, counselors can seek the names of key stakeholders within the community. Asking for opportunities to walk through disaster-ridden communities or arrange for informal group gatherings to share critical knowledge about communities and their histories is helpful in conceptualizing relevant and complex issues that relate to client presentation. In addition to direct contact, counselors can research communities using Internet and library resources. All of these tools enable counselors to become more knowledgeable about the historical narratives of clients with transgenerational trauma.

Recommendation Three: Conceptualize clients within the context of both past and current trauma presentation. As evidenced by the city of New Orleans in general and the case of Arthur specifically, clients may be impacted by both current and historical traumatic events. Thus, an accurate conceptualization must include both perspectives in order to provide for comprehensive assessments and effective interventions.

Case conceptualization is a process of summarizing case information to articulate a client's fundamental behavioral patterns (Sperry, 2005). Accurate case conceptualization can engender positive treatment outcomes and increase counselor effectiveness. However, poor case conceptualization can disrupt rapport building, erode trust, diminish counselor credibility, and negatively influence timeliness of termination (Pedersen & Ivey, 1993).

Recommendation Four: Incorporate and build upon client strengths

resulting from trans-generated coping skills. The unique experiences of clients who have experienced transgenerational trauma may have facilitated the development coping skills (Cross, 1998). Building upon these already established coping skills can be an effective and expedient means of assisting a client in overcoming current risk factors and relevant latent risk factors.

Counselors can elicit coping skills from the client through narrative techniques. If possible, family members can be incorporated into the counseling process in order to make direct connections between the past and the present. Other sources of support might include siblings, neighbors, and co-workers, especially those demonstrating resilience. Counseling can facilitate the client becoming aware of and integrating these coping skills into the current personal narrative. The ultimate goal would be to foster increased client control and agency to generalize these coping skills to present and future situations.

Recommendation Five: Utilize community-based, culturally competent, and client-centered interventions that expedite return to normalcy. In the context of disaster-related transgenerational and current trauma, not only individuals but entire communities are likely to have experienced trauma (Cross, 1998; Halpern & Tramontin, 2007). These individuals and communities may also have developed culturally relevant and community-based coping skills through their previous experiences with disaster. Using community-based interventions that enable residents to offer support to one another can be an effective means of treating individuals and developing community-wide resilience (Levine, 1997).

While many empirical investigations explore trauma among disaster-affected individuals and war survivors, attention should also be paid to the relationship between trauma symptomology and cultural identity (Olatunji, 1997; Stamm, Stamm, Hudnall & Higson-Smith, 2004; Tummala-Narra, 2001). Future research needs to focus on cultural identity development and its impact on the incidence of trauma symptomology among culturally diverse individuals, families, and communities.

Given the demographic profile of the city of New Orleans, counselors working with the survivors of Hurricane Katrina need to consider transgen-centric interventions. Nobles (1986) encourages the use of culture-centered counseling interventions that emphasize collective understanding through a family support group format. Nobles outlines three key culture-centered intervention aspects: spontaneity/flexibility, transcendence, and transformation. Central to this approach is collaboration between client and counselor wherein they identify issues and explore alternative perspectives and behaviors collaboratively. Additionally, he asserts that there is a dynamic stretching that occurs whereby both client and counselor move beyond the traditional boundaries of the presenting problem to create change and growth. Together, client and counselor create new possibilities and discover new discourse.

In summary, the current perspective on trauma when working with disaster survivors may be insufficient to address historical and contextual issues that influence client presentation of symptoms. Transgenerational trauma thereby extends the existing discussion on trauma by including intergenerational factors of both resilience and risk. Such an understanding of transgenerational trauma can enhance counselor effectiveness when conceptualizing and providing expedient interventions in disaster-ridden areas. In the case presented, we sought to illustrate the complexities of transgenerational trauma symptomology as well as the usefulness of resilience theory from a cross-generational perspective. The five recommendations serve as a launch pad from which counselors can begin to explore the personal and collective historical influences in effective disaster mental health response.

REFERENCES

Aarts, P. G. H. (1998). Intergenerational effects in families of World War II survivors from the Dutch East Indies: Aftermath of another Dutch War. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 175–187). New York: Plenum.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Arlington, VA: Author.

Becker, D. (1995). The deficiency of the concept of posttraumatic stress disorder when dealing with victims of human rights violations. In R. J. Kleber, C. R. Figley, & B. P. R. Gersons (Eds.), *Beyond trauma: Cultural and societal dynamics* (pp. 99–110). New York: Plenum.

Bernstein, M. M. (1998). Conflicts in adjustment: World War II prisoners of war and their families. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 119–124). New York: Plenum.

Bonnano, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *The Counseling Psychologist, 59*, 20–28.

Breslau, N. (2002). Epidemiologic studies of trauma, posttraumatic stress disorder, and other psychiatric disorders. *Canadian Journal of Psychiatry, 47*, 923–929.

Brinkley, D. (2006). *The great deluge: Hurricane Katrina, New Orleans, and the Mississippi Gulf Coast*. New York: HarperCollins.

Bromet, E., Sonnega, A., & Kesser, R. C. (1998). Risk factors for DSM-III-R posttraumatic stress disorder: Findings from the National Comorbidity Study. *American Journal of Epidemiology, 147*, 353–361.

Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. *Violence Against Women, 9*, 1293–1317.

Burstow, B. (2005). A critique of posttraumatic stress disorder and the *DSM*. *Journal of Humanistic Psychology, 45*, 429–445.

Calley, N. G. (2007). Promoting an outcome-based treatment milieu for juvenile sexual offenders: A guided approach to assessment. *Journal of Mental Health Counseling, 29*, 121–143.

Centers for Disease Control and Prevention. (2006, January 20). Assessment of health-related needs after Hurricanes Katrina and Rita: Orleans and Jefferson Parishes, New Orleans area, Louisiana, October 17–22, 2005. *Morbidity and Mortality Weekly Report, 55*, 38–41. Retrieved December 2, 2007, from http://cdc.gov/MMWR/preview/mmwrhtml/mm5502a5.htm

Collins, B. G., & Collins, T. M. (2005). *Crisis and trauma: Development-ecological intervention*. New York: Lahaska Press.

Cosgrove, L. (2005). When labels mask oppression: Implications for teaching psychiatric taxonomy. *Journal of Mental Health Counseling, 27*, 283–296.

Costa, J., Nelson, T. M., Rudes, J., & Guterman, J. T. (2007). A narrative approach to body dysmorphic disorder. *Journal of Mental Health Counseling, 29*, 67–80.

Cross, W. E. (1998). Black psychological functioning and the legacy of slavery. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 387–400). New York: Plenum.

Dana, R. H. (1993). *Multicultural assessment perspectives for professional psychology*. Boston: Allyn & Bacon.

Danieli, Y. (1998). Introduction: History and conceptual foundations. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 1–20). New York: Plenum.

Dass-Brailsford, P. (2007). *A practical approach to trauma: Empowering interventions*. Los Angeles: Sage.

Davidson, A. C., & Mellor, D. J. (2001). The adjustment of children of Australian Vietnam veterans: Is there evidence for the transgenerational transmission of the effects of war-related trauma? *Australian and New Zealand Journal of Psychiatry, 35*, 345–351.

DeSalvo, K. B., Hyre, A. D., Ompad, D. C., Menke, A., Tynes, L. L., & Muntner, P. (2007). Symptoms of posttraumatic stress disorder in a New Orleans workforce following Hurricane Katrina. *Journal of Urban Health, 84*, 142–152.

Duran, E., Duran, B., Yellow Horse Brave Heart, M., & Yellow Horse-Davis, S. (1998). Healing the American Indian soul wound. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 341–354). New York: Plenum.

Duval, J., & Beres, L. (2007). Movement of identities: A map for therapeutic conversations about trauma. In C. Brown & T. Augusta-Scott (Eds.), *Narrative therapy: Making meaning, making lives* (pp. 229–250). Thousand Oaks, CA: Sage.

Echterling, L. G., Presbury, J. H., & McKee, J. E. (2005). *Crisis intervention: Promoting resilience and resolution in troubled time*. Upper Saddle River, NJ: Pearson Education, Inc.

Eriksen, K., & Kress, V. E. (2006). The *DSM* and the professional counseling identity: Bridging the gap. *Journal of Mental Health Counseling, 28*, 202–217.

Felsen, I. (1998). Transgenerational transmission of effects of the Holocaust. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 43–68). New York: Plenum.

Fischetti, M. (2001). Drowning New Orleans. *Scientific American, 285*, 76–85.

Franks, J. (2007, August 29). Slow recovery goes on in crime-weary New Orleans. *Reuters*. Retrieved September 9, 2007, from http://www.reuters.com

Frazier, R. (2006, April 5). New Orleans: Seven months later. *The Brown Daily Herald*. Retrieved September 12, 2007, from http://www.browndailyherald.com

Freedy, J. R., & Simpson, W. M. (2007). Disaster-related physical and mental health: A role for the family physician. *American Family Physician, 75*, 841–848. Retrieved December 2, 2007, from Academic OneFile.

Galea, S., Nandi, A., & Vlahov, D. (2005). The epidemiology of post-traumatic stress disorder and disasters. *Epidemiological Reviews, 27*, 78–91.

Gardner, F. (1999). Transgenerational processes and the trauma of sexual abuse. *European Journal of Psychotherapy, Counseling & Health, 2*, 297–308.

Greater New Orleans Community Data Center. (2007, June). *The Katrina Index: Tracking recovery of New Orleans & the Metro area*. Retrieved July 19, 2007, from http://www.gnocdc.org/KI/KatrinaIndex.pdf

Guha-Sapir, D., Hargitt, D., & Hoyois, P. (2004). *Thirty years of natural disasters 1974–2003: The numbers*. Louvain-la-Neuve, Belgium: Presses universitaires de Louvain.

Halpern, J., & Tramontin, M. (2007). *Disaster mental health: Theory and practice*. Belmont, CA: Thompson Brooks/Cole.

Harvey, M. R., Liang, B., Harney, P. A., Koenen, K., Tummala-Narra, P., & Lebowtiz, L. (2003). A multidimensional approach to the assessment of trauma impact, recovery and resiliency: Initial psychometric findings. *Journal of Aggression, Maltreatment & Trauma, 6*, 87–109.

Harvey, M. R., & Tummala-Narra, P. (2007). Sources and expression of resilience in trauma survivors: Ecological theory, multicultural perspectives. *Journal of Aggression, Maltreatment & Trauma, 14*, 1–7.

Harvey, M. R., Westen, D., Lebowitz, L., Saunders, E., Avi-Yonah, O., Harney, P. A., et al. (2007). Appendix A: Multidimensional Trauma Recovery and Resiliency Scale (MTRR-99) clinical rating form. *Journal of Aggression, Maltreatment & Trauma, 14*, 307–313.

Herman, J. (1997). *Trauma and recovery*. New York: Basic Books.

Hooper, L. M. (2007). Expanding the discussion regarding parentification and its varied outcomes: Implications for mental health research and practice. *Journal of Mental Health Counseling, 29*, 322–337.

Hsu, E., Davies, C. A., & Hansen, D. J. (2004). Understanding mental health needs of Southeast Asian refugees: Historical, cultural, and contextual challenges. *Clinical Psychology Review, 24*, 193–213.

Hughes, H. M., Humphrey, N. H., & Weaver, T. L. (2005). Advances in violence and trauma: Toward comprehensive ecological models. *Journal of Interpersonal Violence, 20*, 31–38.

Ibrahim, F. A., Roysircar-Sodowsky, G., & Ohimshi, H. (2001). Worldview: Recent developments and needed directions. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.). *Handbook of multicultural counseling* (2nd ed., pp. 425–456). Thousand Oaks, CA: Sage Publications.

Ivey, A. E., & Ivey, M. B. (1998). Reframing *DSM-IV*: Positive strategies from developmental counseling theory. *Journal of Counseling & Development, 76*, 334–350.

James, R. K., & Gilliland, B. E. (2005). *Crisis intervention* strategies (5th ed.). Belmont, CA: Brooks/Cole.

Jordan, K. (2004). The color-coded timeline trauma genogram. *Brief Treatment and Crisis Interventions, 4*, 57–70.

Kira, I. A. (2001). Taxonomy of trauma and trauma assessment. *Traumatology, 7*, 73–86.

Levine, P. A. (1997). *Waking the tiger: Healing trauma*. Berkeley, CA: North Atlantic Books.

McLaughlin, J. E. (2002). Reducing diagnostic bias. *Journal of Mental Health Counseling, 24*, 256–269.

Mead, M. A., Hohenshil, T. H., & Kusum, S. (1997). How the *DSM* system is used by clinical counselors: A national study. *Journal of Mental Health Counseling, 19*, 383–402.

Nagata, D. K. (1990). The Japenese American Internment: Exploring the transgenerational consequences of traumatic stress. *Journal of Traumatic Stress, 3*, 47–69.

Nobles, W. W. (1986). Ancient Egyptian thought and the development of African (Black) psychology. In M. Karenga & J. H. Carruthers (Eds.), *Kemet and the African worldview: Research, rescue and restoration* (pp. 100–118). Los Angeles: University of Sankore Press.

Olatunji, C. A. (1997). Culture-centeredness training as an intervention for chronic racism-related post-traumatic stress disorder symptoms in African-American adolescents. Unpublished dissertation: University of New Orleans.

Pedersen, P. B., & Ivey, A. (1993). *Culture-centered counseling and interviewing skills: A practical guide*. Westport, CT: Praeger.

Raphael, B., Swan, P., & Martinek, N. (1998). Intergenerational aspects of trauma for Australian Aboriginal people. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 327–339). New York: Plenum.

Rogers, J. R. (2007). Disaster response and the mental health counselor. *Journal of Mental Health Counseling, 29*, 1–3.

Rosenheck, R., & Fontana, A. (1998a). Transgenerational effects of abusive violence on the children of Vietnam combat veterans. *Journal of Traumatic Stress, 11*, 731–742.

Rosenheck, R., & Fontana, A. (1998b). Warrior fathers and warrior sons: Intergenerational aspects of trauma. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 225–242). New York: Plenum.

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment.* New York: W. W. Norton & Company, Inc.

Scaer, R. C. (2001). *The body bears the burden: Trauma, dissociation, and disease.* Binghamton, NY: The Haworth Press, Inc.

Schechter, D. S., Brunelli, S. A., Cunningham, N., Brown, J., & Baca, P. (2002). Mother-daughter relationships and sexual abuse: A pilot study of 35 days. *Bulletin of the Menninger Clinic, 66,* 39–60.

Seligman, L. (1999). Twenty years of diagnosis and the *DSM. Journal of Mental Health Counseling, 21,* 229–240.

Simons, R. L., & Johnson, C. (1998). An examination of competing explanations for the intergenerational transmission of domestic violence. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 553–570). New York: Plenum.

Sperry, L. (2005). Case conceptualizations: The missing link between theory and practice. *Family Journal: Counseling and Therapy for Couples and Families, 13,* 71–76.

Spacceralli, S., & Kim, S. (1995). Resilience criteria and factors associated with resilience in sexually abused girls. *Child Abuse & Neglect, 19,* 1171–1182.

Stamm, B. H., Stamm, H. E., Hudnall, A. C., & Higson-Smith, C. (2004). Considering a theory of cultural trauma and loss. *Journal of Loss and Trauma, 9,* 89–111.

Suzuki, L. A., Meller, D. J., & Ponterotto, J. G. (1996). Multicultural assessment: Present trends and future directions. In L. A. Suzuki, D. J. Meller, & J. G. Ponterotto (Eds.), *Handbook of multicultural assessment: Clinical, psychological, and educational applications* (pp. 673–684). San Francisco: Jossey Bass.

Tummala-Narra, P. (2001). Asian trauma survivors: Immigration, identity, loss, and recovery. *Journal of Applied Psychoanalytic Studies, 3,* 243–258.

Tummala-Narra, P. (2007). Trauma and resilience: A case of individual psychotherapy in a multicultural context. *Journal of Aggression, Maltreatment & Trauma, 14,* 205–225.

U.S. Committee for Refugees and Immigrants. (2006). *World Refugee Survey 2006.* Washington, DC: Author.

van der Kolk, B. A., & McFarlane, A. C. (1996). The black hole of trauma. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress* (pp.3–23). New York: The Guilford Press.

Walker, M. (1999). The inter-generational transmission of trauma: The effects of abuse on the survivor's relationship with their children and on the children themselves. *The European Journal of Psychotherapy, Counseling & Health, 2,* 281–296.

Waller, M. A. (2001). Resilience in ecosystemic context: Evolution of the concept. *American Journal of Orthopsychiatry, 71,* 290–297.

Walsh, F. (2002). A family resilience framework: Innovative practice applications. *Family Relations, 51,* 130–137.

Walter, J. (Ed.). (2005). *World disaster report, 2005: Focus on information in disasters.* Bloomfield, CT: International Federation of Red Cross and Red Crescent Societies.

Weisler, R. H., Barbee, J. G., & Townsend, M. H. (2006). Mental health and recovery in the Gulf Coast after Hurricanes Katrina and Rita. *Journal of the American Medical Association, 296,* 585–588.

White, V. E. (2002). Developing counseling objectives and empowering clients: A strength-based intervention. *Journal of Mental Health Counseling, 24,* 270–279.

Williams-Clay, L., West-Olatunji, C., & Cooley, C. (2001). *Keeping the story alive: Narrative in the African-American church and community.* (ERIC Document Reproduction Service No. ED462666).

World Health Organization. (2005). *Violence and disasters.* Geneva, Switzerland: Author.