Project Heal Generational Trauma: A Mixed-methods Participatory Action Research Study of Generational Trauma and Healing in Millennial Black Women

Ashlei A R Petion

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PROJECT HEAL GENERATIONAL TRAUMA: A MIXED METHODS PARTICIPATORY ACTION RESEARCH INVESTIGATION OF GENERATIONAL TRAUMA AND HEALING IN MILLENNIAL BLACK WOMEN

by

ASHLEI PETION

Under the Direction of Catherine Y. Chang

ABSTRACT

Generational trauma (GT) is the transmission of the effects of psychologically harmful events from generation to generation through epigenetics, parenting, and other socialization factors. It has been associated with attachment issues, suicidal ideations and behaviors, dysfunctional familial relationships, cultural mistrust, and other health problems such as increased symptoms of posttraumatic stress disorder, elevated mortality rate, and substance misuse, especially within multiple marginalized populations such as millennial Black women (MBW) (Bar-On et al., 1998; Brave Heart, 1999; Mohatt et al., 2014; Wilkins et al., 2013). The current study contributes to existing literature to further understand the GT experiences of MBW and their self-efficacy with regard to addressing GT within their families. A sequential
exploratory mixed methods research design (quan → QUAL → quan) and a participatory action research framework were used to facilitate members’ (participants’) deeper understandings of GT and enhanced self-efficacy for addressing GT. Each of the twelve members (participants) engaged in a ten-week process including: (a) a pre-survey of trauma history and self-efficacy (Chen et al., 2001; Hooper et al., 2011), (b) an individual interview, (c) an eight-week, weekly support group, (d) a mid-point focus group interview, and (e) a post-survey of self-efficacy (Chen et al., 2001). Findings were cross-analyzed using critical discourse analysis (qualitative) and dependent t-tests (quantitative) to reveal six themes: (a) deepened awareness, (b) intentional community, (c) “abnormalizing” the normal, (d) exposure to complexity, (e) turning inward, and (f) taking action (the last three themes were developed through changes in self-efficacy). Implications for individuals, communities, counseling, counselor education, and future research are discussed.

INDEX WORDS: generational trauma, generational healing, millennial Black women, participatory action research, mixed methods research, self-efficacy
PROJECT HEAL GENERATIONAL TRAUMA: A MIXED METHODS PARTICIPATORY ACTION RESEARCH INVESTIGATION OF GENERATIONAL TRAUMA AND HEALING IN MILLENNIAL BLACK WOMEN

by

ASHLEI PETION

A Dissertation

Presented in Partial Fulfillment of Requirements for the Degree of Doctor of Philosophy in Counselor Education and Practice in Counseling and Psychological Services in the College of Education & Human Development Georgia State University

Atlanta, GA
2022
DEDICATION

It is with genuine gratitude and warm regard that I dedicate this work to my mother, Akila Regina Kennedy Wilson. Whether you know it or not, you have contributed so much to the generational healing in our family. I am honored to carry the torch. I also dedicate this work to my late grandfather, Ronald Kennedy, who was a staunch supporter of my pursuit of education. You are sorely missed, and part of your legacy will always persist through me. Lastly, to the twelve brave millennial Black women who dedicated their time and vulnerability to participating in this study, I thank you. This would not have been possible without you, and I hope that your journeys in generational healing was made better because of this study.
ACKNOWLEDGMENTS

To my devoted committee members: thank you for pouring into me. Dr. Chang, I thank you for taking a chance on the young master’s student who approached you at a conference, eager to work with you. Your mentorship and the countless opportunities you’ve shared with me have lifted me up throughout my program, all the way to the finish line. Dr. Fournillier, I am forever grateful that our paths crossed in Qual II class. You inspire me to be a better researcher and human. Your fervent authenticity encourages me to show up as my whole self even when it’s not the norm. Dr. Shannonhouse, you single-handedly shattered my imposter syndrome about studying generational trauma. I will always cherish our late-night talks after Crisis classes. Thank you for always affirming my skills, my knowledge, and my place in this profession and the world. Dr. Mitchell, your dissertation defense was the first one I’d ever seen. From that day forward, I knew that I could do it too. Thank you for taking me under your wing, guiding me, and giving me answers to questions I didn’t know that I needed to ask. I will always “pay it forward” just as you’ve instructed me. I’m so grateful to have a committee of powerful and empowering women who embody all the qualities that I wish to have as a counselor educator, researcher, and professional counselor. Thank you for believing in me and pushing me to greatness.

To my dear colleagues and friends, soon-to-be Dr. Deaetta Grinnage and soon-to-be Dr. Marshaya Rountree: thank you for rocking with me throughout my doctoral journey! I’m so grateful that our paths crossed at GSU, and I’m honored to have a front row seat to each of your successes. Know that our mentoring relationships have always been reciprocal; I’ve learned as much from you as you’ve learned from me. I’m ever grateful for the time and energy you’ve poured into this study. To my dear cohort members: Dr. Jamian Coleman, Dr. Kyndel Tarziers,
and soon-to-be Dr. Merideth Ray: We did it! I’ve enjoyed going through this challenging process with each of you. May the bond we’ve created in this program carry us throughout our careers. The best is yet to come.

To my best girlfriends, Viona Joseph, Arlena Binkley, Shikira McNish, and Christina Mbuya: thank you for always checking in on me, encouraging me to rest, sharing my studies and accomplishments, and for being the best friends a PhD student could ask for. Our conversations and girls’ trips gave me many moments to look forward to that motivated me towards the finish line. I love you all, always! To my sister, Aaliyah Wilson, thank you for our late night, FaceTime study dates. You’ve held me accountable and motivated me to no end. Knowing that you were looking up to me is oftentimes what kept me going. Know that you can accomplish anything you plan to. I love you! To my mommy, Akila “Gina” Wilson, you are the reason for it all. You are my role model, my inspiration, and my biggest cheerleader. Thank you for holding me down, lifting me up, and warmly answering all my frantic phone calls with the calmness and reassurance that only a loving mother could embody. I love you.

And to my husband and best friend, Giscard: You’ve been by my side through it all! From applying to PhD programs to accepting my first faculty position, your unwavering support, encouragement, and mere presence have been paramount in my success. Embarking on this scholarly journey with you is something I will cherish forever. May our legacy be reflective of this work; breaking “generational curses” and fostering a healthy family of our own together. I love you and I appreciate you.
# TABLE OF CONTENTS

1 HOW “GENERATIONAL” IS TRAUMA? AN OVERVIEW OF THE LITERATURE AND CONSIDERATIONS FOR RESEARCH................................................................. 1

   REVIEW OF MAJOR CONSTRUCTS................................................................. 1

   THE PROPOSED STUDY ON GENERATIONAL TRAUMA AND HEALING... 13

   IMPLICATIONS..................................................................................................18

   REFERENCES................................................................................................. 21

2 PROJECT HEAL GENERATIONAL TRAUMA: A MIXED METHODS PARTICIPATORY ACTION RESEARCH INVESTIGATION OF GENERATIONAL TRAUMA AND HEALING IN MILLENNIAL BLACK WOMEN........................................... 29

   GENERATIONAL TRAUMA ........................................................................... 28

   STUDY FRAMEWORK ..................................................................................33

   ROLES .........................................................................................................42

   PROCEDURE ..................................................................................................47

   RESULTS........................................................................................................55

   DISCUSSION.................................................................................................. 76

   CONCLUSIONS............................................................................................ 91

   REFERENCES............................................................................................... 92

APPENDICES ................................................................................................. 100
1 HOW “GENERATIONAL” IS TRAUMA? AN OVERVIEW OF THE LITERATURE AND CONSIDERATIONS FOR RESEARCH

There is a solid body of literature on the physical and psychological effects that traumatic events and experiences can have on an individual. From being considered ‘resolved’ at the offset of a traumatic event to exploring more lasting, relational effects, researchers’ and clinicians’ understanding of trauma has drastically deepened. An adjacent, growing body of literature focuses on the lasting and interpersonally transferable effects of trauma. Through the narratives and study of trauma, vicarious trauma, historical trauma, and generational trauma, researchers and clinicians have come to understand that: (a) trauma can make changes to not only the human psyche but also human gene expression, and (b) an individual need not be present at the time of a traumatic event to be significantly affected by it (i.e., a transmission process occurs) (Crawford, 2014; Herman, 1992; Krippner & Barrett, 2019). However, how trauma is transmitted between individuals and across generations is not as well understood. Additionally, there is minimal literature on populations with unique experiences with trauma. In this manuscript, the author outlines major constructs related to generational trauma to set the stage for a mixed-methods, participatory action research study that aims to explore avenues for a deeper understanding and healing of generational trauma among millennial African American women.

Review of Major Constructs

Generational trauma is a phrase comprised of two complex words, ‘trauma’ being the noun or the root of the term and ‘generational’ being the descriptive adjective to describe the noun. Because trauma itself is a complex term with developing understandings, attention is first given to exploring the meaning of trauma, how the conceptualization of trauma has changed over
time, and what is known about its general prevalence. Despite the prevalence of trauma across populations and settings, crisis-and trauma-related training courses within counselor preparation graduate programs are still not required nor commonplace, which could lead to a lack of effective client treatment and potentially clinical harm (Morris & Minton, 2012). Without an initial understanding of more individualized trauma, professional counselors may fail to recognize and effectively treat individuals presenting with more complex forms of trauma. Trauma is explored via a collective, generational lens using both social and biological theories of transmission, as these are the two primary avenues through which it has been explained. Further, studies of various populations with generational trauma are presented, and a gap in the literature is identified through which the following research will emerge and contribute to the literature.

Trauma

History of Trauma Definitions

Before exploring what is understood about generationally transmitted trauma, it is important to understand the journey of the conceptualization of trauma over time. The word ‘trauma’ derives from the Greek word for ‘wound’, and there are writings that acknowledge traumatic experiences dating back to the Middle Ages (Jones & Cureton, 2014). Initial characterizations of clinical implications of trauma appeared in the late 19th century by Sigmund Freud and Pierre Janet. They developed theories on the etiology of hysteria, specifically psychological and sexual trauma (Herman, 1992). Throughout much contention, debate, and censoring, investigations of trauma pivoted to focus on combat (soldiers’ reactions to wartime experiences) and interpersonal violence (domestic violence against women and children) (Herman, 1992). These investigations led to the emersion of ‘posttraumatic stress disorder’ (PTSD) in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-
Prior to this initial PTSD diagnosis, previous iterations of the DSM identified reactions to stressful experiences as a “transient situational disturbance”, suggesting a temporary response to a temporary event; both of which would subside and dissipate (Yehuda & Bierer, 2009). Thus, responses to stress, including traumatic stress, were conceptualized to have effects that were temporary (i.e., not long-lasting). As the stressor subsided, so would the individuals’ responses (or so it was believed). Definitions and understandings of stress, traumatic experiences, and symptoms of PTSD have transformed to be more comprehensive and inclusive.

The *DSM-IV* and *DSM-IV-TR* expanded the scope of traumatic experiences to include car accidents, natural disasters, learning about the death of a loved one, and even difficult divorces (American Psychiatric Association, 1994, 2000). This led to a 59% spike in trauma diagnoses and contributed to a more modern, continuum-like conceptualization of trauma and traumatic responses (Breslau & Kessler, 2001). According to Jones and Cureton (2014), extensive debates took place during the 13 years between the *DSM-IV-TR* (2000) and the *DSM-5* (2013) about how trauma is defined and which core criteria constitute a diagnosis of PTSD. The following questions permeated those debates: (a) Is trauma just another type of anxiety disorder? (b) Do individuals who experienced an event firsthand and those who witnessed it secondhand or vicariously deserve equivalent diagnoses? (e.g., World Trade Center bombing survivors versus those who learned about it in different parts of the country via news outlets) (c) How can two individuals who experience the same stressor have two vastly different responses to it, and how do we classify them when only one of them may develop symptoms of PTSD? (d) How do we classify unconscious responses (e.g., emotional numbing) compared to more intentional ones.
(e.g., avoidance)? (e) Were previous diagnoses inclusive of children and adolescents’

experiences with trauma?

In the continued quest for a better understanding of trauma, the DSM-5 endorsed a new
category of diagnoses: trauma- and stressor-related disorders (TSRDs; American Psychiatric
Association, 2013). In sum, the changes encompassed: (a) moving away from the ‘anxiety
disorders’ subcategory and into its category of TSRDs; (b) ‘exposure’ to include learning a
traumatic event occurred to a close family member or friend, and vicarious trauma; (c) the
addition of persistent negative emotional states, persistent blame, and reckless or self-destructive
behavior as new symptoms; and (d) two new types: dissociative symptoms (i.e.,
depersonalization or derealization) and delayed expression of six months or more (American
Psychiatric Association, 2013). Essentially, trauma came to be regarded as a dynamic, fluid-like
process involving an event (or series of events) and the individual’s and community’s capacity
for resilience and protective factors (Gerber & Gerber, 2019). Additionally, trauma came to be
viewed in a narrative format, such that it contains both personal and shared components and that
each individual develops their trauma narrative surrounding an experience that may or may not
be shared (Mohatt et al., 2014). The most notable change for professional counselors and first
responders alike was acknowledging vicarious trauma. About 15-20% of clinicians identified
having experienced through their trauma work with clients (Arvay & Uhlemann, 1996; Meldrum
et al., 2002). It is apparent how complex these conversations about trauma can become when we
consider how trauma is shared with others via narratives and similar experiences.

Vicarious trauma, developed from constructivist self-development theory, is defined as
unfavorable cognitive and affective changes resulting from exposure to second-hand traumatic
material (McCann & Pearlman, 1990). Humans are social, interdependent beings; therefore, it is
no surprise that witnessing a traumatic event or witnessing another person endure or describe their trauma can be traumatic for the listener or observer. Despite an abundance of literature to support evidence of vicarious trauma in mental health professionals and first responders, those groups are not the only ones affected by this phenomenon. There is supporting evidence of vicarious trauma for other groups such as legal professionals (Hodge, Jr. & Williams, 2021), dental care workers (Uziel et al., 2019), foster parents (Bridger et al., 2020), and even academics and researchers (Nikischer, 2019). Thus, how vicarious trauma, and ultimately trauma at large, has been conceptualized has widened to be more representative.

**Prevalence**

While much of the literature on trauma is centered around TSRDs and PTSD, it is apparent that an individual need not meet the criteria of PTSD to experience trauma or be affected by it. Exact statistics on the prevalence of trauma are difficult to attain because if a report is not made or treatment sought out, the incidents are not recorded (Gerber & Gerber, 2019). Survivors of trauma may not be aware of the parameters of TSRD symptomology and thus may not self-identify as having experienced a trauma. Additionally, because many forms of trauma have overlapping definitions and individuals may experience multiple traumas over their lifetime, the experiences may become normalized and thus are less likely to be reported. Cultural norms relevant to various demographics (e.g., gender, sexual orientation/attraction, race/ethnicity, etc.) might also hinder a person from reporting the trauma and seeking professional help. Despite these limitations, nearly five out of every six clients seen in community mental health clinics identify as having at least one traumatic experience in their lifetime (Breslau & Kessler, 2001). About 70% of adults in the United States (U.S.) have experienced some type of traumatic event at least once in their lives (The National Council for
Behavioral Health, 2013). If an individual is not directly impacted by trauma, there is a strong chance that they are close to someone who has been affected by trauma, thus exposing them to the risk of vicarious trauma. In essence, trauma is nearly inevitable, permeating aspects of society from multiple angles and across the lifespan.

Exposure to trauma continues to persist and potentially increase in society. Thus, a few questions remain: If traumatic responses do not ‘resolve’ at the subsidence of the stressor, and trauma can have lasting effects on the human psyche, is it possible to transmit the impact of trauma to others? If so, how do these processes function? What happens to individuals who experience trauma in large groups and for extended periods?

**Generational Trauma**

**Social Theories of Generational Trauma**

GT, intergenerational trauma, transgenerational trauma, and historical trauma are overlapping terms that describe complex and collective trauma experienced over time and across generations shared by a group of people with a common identity, affiliation, or circumstance (Bar-On et al., 1998; Brave Heart & DeBruyn, 1998; Crawford, 2014; Evans-Campbell, 2008; Gone, 2013). According to Mohatt et al. (2014), GT consists of three primary elements: (a) trauma or wounding; (b) shared by a group of people rather than individually experienced; and (c) spanning multiple generations, such that contemporary members of the group may experience trauma-related symptomology without having been present for the past traumatizing events.

It is also noted that GT can encompass larger groups such as entire ethnic backgrounds or smaller groups such as a specific family lineage or village (Mohatt et al., 2014). A key point related to this understanding is that GT has a narrative component. At the same time, a
A person’s memory can validate the trauma; the trauma must be expressed outwardly or represented in stories told by those who experienced it to others who did not directly experience the traumatic events. When considering a more collective trauma such as GT, we rely on both personal and public narratives to sustain what is known about how ancestors experienced and were affected by traumatic events, including both anecdotal and empirical sources of knowledge, both within particular family units and across larger ethnic groups (Mohatt et al., 2014). This distinction between familial and ethnic group knowledge is important because many minoritized ethnic groups who identify as having GT (e.g., African Americans) are historically underrepresented or misrepresented in academia and research and have maintained separate systems of research and knowledge beyond what is structured by the academy (Barlow & Dill, 2018). All in all, social theories of GT support the understanding that what is known about GT is passed down within families and across ethnic groups through the use of cultural narratives, whether that be in qualitative interviews, historical dialogue, nontraditional artifacts, and even modern social media and networking.

**Biological Theories of Generational Trauma**

While the narrative conceptualization of trauma and GT is validated through socialization and dialogue, it would be remiss not to mention the more biological conceptualization of the transmission of trauma. The word ‘epigenetic’ was introduced in the 1940s to describe how growing cells maintain and establish their identities through various developmental stages (the prefix ‘epi’ meaning ‘on, upon, or on top of,’ insinuating something in addition to the basic genetic makeup) (Waddington, 2014). Epigenetics, the biological field of study, is the study of cellular variations in DNA expression caused by external, and environmental factors, and is more simply thought of as a “very specific sort of memory” of
According to Krippner and Barrett (2019), some effects of trauma can be inherited even when the offspring are not raised by the parent who experienced the trauma. Relatedly, Dias and Ressler (2014) conducted one of the many experiments on nonhuman animals and found that when mice were conditioned to be fearful of the smell of cherry blossoms paired with a shock to the foot, the structure of a mouse’s nose was altered to be more sensitive to that particular smell. As a result, their pups and even their pups’ pups were independently fearful of cherry blossom smells (i.e., one need not be mindful of the impact of trauma to be impacted by it). This study presents evidence for a multigenerational transmission process of trauma, and there are human-based studies with similar supporting evidence. Several studies of children of adults with histories of traumatic experiences reported having a heritability effect comparable to what has been found in nonhuman animals, including an increased likelihood of developing symptoms of PTSD and lower levels of cortisol (i.e., the hormone that regulates stress in the body) than control group members. These studies included war veterans, Holocaust survivors, famine and disaster survivors, and pregnant women who witnessed the September 11, 2011, attacks on the World Trade Center (Yahyavi et al., 2013; Yehuda & Bierer, 2009).

Both biological and social theories are considered in how GT is transmitted across generations. However, because history is essentially collective memory, it is a highly malleable process that is not exempt from the unfortunately conventional attempts to silence and misconstrue the lived experiences of marginalized groups (Antze & Lambek, 1996; Zembylas & Bekerman, 2008). That is, how history has been defined, shaped, and acknowledged over time is inextricably linked to how dominant cultures and oppressive forces have attempted to invalidate the lived experiences of minoritized groups and even limit
or harshly regulate what can be shared publicly (e.g., verbally and in print). It should also be noted that while initial events can be classified as traumatic, so can the attempts to further silence and suppress the narratives of marginalized groups. Hence, one can see how understanding trauma and GT becomes increasingly complex as we consider how interactions with society may impact their definitions and manifestation.

**Populations Studied**

Although GT was initially understood to characterize the experience of children of Holocaust survivors, the term has since been explored through the lens of other colonized, marginalized, and indigenous groups who have suffered from genocide, mass violence, and other traumatic events, including Native Americans, Armenian refugees, Japanese internment camp survivors, Swedish immigrants, Palestinian youth, Cambodian refugees, Mexican Americans (Daud et al., 2005; Evans-Campbell, 2008; Karenian et al., 2011; Wexler et al., 2009). Furthermore, derivative concepts such as soul wounds and Post Traumatic Slave Syndrome have been used to describe specific effects of Native American and African American peoples, respectively (DeGruy, 2017; Duran, 2006). Despite ample empirical evidence for how GT has impacted other populations and a growing body of literature dedicated to GT in African Americans, there remain ample avenues to expand the literature regarding how African Americans experience GT today, including pathways to transformation and healing. While anecdotal GT narratives and dialogues continue to increase in African American families and communities, it is imperative that the literature is reflective of these experiences. We explore the empirical evidence that currently exists regarding GT and African Americans.
Generational Trauma in African Americans

The very presence of African Americans in the United States indicates the history and presence of trauma. Nearly four centuries ago, West Africans representing several different tribes, regions, professions, ages, social statuses, and languages were forcefully kidnapped from their native lands to embark upon the transatlantic slave trade. Many did not survive the journey from West Africa to the Americas. Enslaved Africans endured horrific, dehumanizing treatment from White colonizers spanning additional centuries as the divided land fought over the right to own enslaved Africans. Despite emancipation, slavery for African Americans mutated into different forms: segregation, the Jim Crow era, lynching, the Civil Rights Movement, the War on Drugs and mass incarceration, police brutality, and more. The effects of slavery are long-term and inter-generational.

Currently, over 46.8 million Black and African American individuals make up 13.4 percent of the United States population (United States Census Bureau, 2018). Despite this number, African Americans account for 37.7 percent of U.S. prison inmates (Federal Bureau of Prisons, 2020). Moreover, according to the National Center for Education Statistics (NCES, 2018), Black children make up 31 percent of all children living in poverty in the U.S. Disparities against African Americans also extend to the public health arena. Although the death rate for African Americans has decreased 25 percent from 1999 to 2015, African Americans ages 18 to 49 are still twice as likely to die from heart disease than their White counterparts, and African Americans ages 35 to 64 are 50 percent more likely to have high blood pressure than their White counterparts (Center for Disease Control and Prevention, 2017). Given this array of social, educational, and physical disparities against African Americans, we are led to wonder how
transgenerational processes continue to play a part in helping to perpetuate these disparities on all levels, not to mention the relational, familial, and communal effects of race-based trauma.

Wilkins et al. (2013) identified present-day effects on two levels: the individual psyche and the family system. They describe feelings of rage and passivity amongst present-day African Americans, which they suggest is connected to the mental functioning of the enslaved Africans. The enslaved person was forced to stifle their natural response to oppression (i.e., anger, rage) in order to survive. They purport that this same stifled rage shows up as being afraid to be too outspoken or problematic in fear of retribution. Further, this repressed rage is disguised as passivity to navigate oppression, although sometimes mislabeled as laziness, lack of concern for advancement and wellbeing, etc. This, coupled with the justified cultural mistrust of White Americans, yields a tumultuous relationship between the two communities.

Since the residual effects of slavery deeply impact individuals’ psyches, it is expected that these long-lasting effects also permeate interpersonal relationships and families (Wilkins et al., 2013). Wilkins et al. (2013) also purport that the primary function of the family unit is to serve as a facilitator and support to what is experienced in the outside world and to aid in the successful socialization of children; and that because slavery required African American parents to teach their children how to survive oppressive, harsh conditions, many African American children are socialized not to challenge oppressive systems which leads to feelings of powerlessness and passiveness. For historical context, enslaved African children who acquired adult-level competencies (e.g., walking, talking, coordination, etc.) were frequently taken from their parents and put to work (Wilkins et al., 2013). The trauma of this practice has resulted in many African American parent’s fear of loss, which connects to them struggling to, or refraining from, praising their children for reaching developmental milestones (Wilkins et al., 2013). The
underlying logic is that if a child achieves a milestone (e.g., taking a first step) and the parent praises that action, the child will continue to engage in that action, putting them in danger of being taken away from the family. In the present day, this can look like African American parents having difficulty acknowledging their children’s accomplishments, often downplaying them to further humble them. However, the underlying goal of safety in society is often understated, leading to discord between parents and children.

Wilkins et al. (2013) also touched on the African American family system during slavery, which was more matriarchal due to African American men being sold and African American women being kept for the purposes of rape mothering, and wet nursing by enslavers and their families. The emancipation of enslaved Africans also led to more disorganization amongst African American family units, which contributed to tumultuous family relationships. This has also been demonstrated in contemporary research. Petion et al. (2021) interviewed African American women college students and found phenomenological themes of “functioning in dysfunction,” “collectivistic yet disconnected,” and gendered differences in how GT is experienced. Normalized avoidance of deeply rooted issues and harmful generational patterns, a superficial closeness of family members lacking in genuine relationships, and the burden falling on female family members to address relational dynamics and concerns showed up throughout the data.

Lacking from the African American GT literature is a deeper exploration of GT in African American women. At a minimum, African American women hold two intersecting, minoritized identities resulting in both race- and gender-based discrimination and even violence. The aforementioned pressure placed upon African American women to be the initiators and mediators of family trauma and relationships is worth additional study, especially since similar
findings have emerged for other minoritized populations of women (Brave Heart, 1999). A particular subset of African American women that are also worthy of further study is millennial Black women (MBW) (i.e., born between 1981 and 1996; currently aged 25 to 40). Millennials are the largest racially and ethnically diverse generational group in U.S. history, with about 40 percent of adult millennials being persons of color (DeBard, 2004; Howe & Strauss, 2000; Madland & Teixeira, 2009). Yet, empirical studies lack culturally relevant perspectives on their experiences (Apugo, 2017).

Further, MBW are the generation that currently spans the traditional child-bearing and parenting age range. A focus on their experiences of GT and working to implement change in familial and communal processes has the potential to reach a wide array of family and community systems. Overall, the goal is to interrupt the transmission of GT with culturally appropriate interventions. If MBW are better equipped to address GT within their families, this contributes to decreasing the stigma surrounding this topic and could also create a ripple effect of healing in interpersonal relationships (Petion et al., 2021). Additionally, if mental health professionals have a better understanding of GT transmission and healing processes, they are better equipped to empathize with and serve clients in their respective settings with empirically based interventions.

Based on existing literature, it is imperative to investigate culturally appropriate methods (e.g., group work and subsequent group activities) for further researching and disrupting the transmission of GT. Group work interventions, in which several individuals are joined together by group facilitators to dialogue and work through a shared issue or concern, and participatory action research, a framework focused on improving the lives of participants through reflexivity
and action, are two viable, potentially synergistic approaches that could be used to study further and uncover ways to disrupt the transmission of GT.

**The Proposed Study on Generational Trauma and Healing**

**Participatory Action Research**

Participatory action research (PAR) is an emancipatory practice that aims to improve the lives of participants and reduce or eliminate inequities they experience by involving individuals to take action in their circumstances (Baum et al., 2006; Herr & Anderson, 2015). Further, Herr and Anderson (2015) outline the following action cycles as central to PAR: (1) develop a plan of action to improve what is already happening, (2) act to implement the plan, (3) observe the effects of action in the context in which it occurs, (4) reflect on these effects as a basis for further planning and action (p. 5). GT is an issue that plagues the lives, mental health, and relationships of many African Americans. Yet, many remain hopeful for a change despite their lack of a clear, accessible way to approach this grand problem (Petion et al., 2022). Given the phenomenon of GT, existing literature, and subsequent gaps of knowledge and evidence-based approaches for healing, this PAR-based study could serve as the link between an issue spanning generations and a community hopeful for positive change and whose values align closely with the tenets of the proposed approaches. A more extensive description of how these interventions will be utilized within this study is explained in the following chapter.

**Group Work**

Researchers have demonstrated that group work is a primary method for empowering individuals to achieve their goals and that groups are efficient and relevant to diverse populations and purposes (McCarthy et al., 2021). Moreover, Black individuals across the African diaspora (i.e., descendants of native African peoples across the world) have long been associated with
collectivism and communal cultural norms due to their African roots (Baldwin & Hopkins, 1990; Gushue & Constantine, 2003). African Americans are defined as bicultural due to living in the United States but having residual African cultural norms and practices following the transatlantic slave trade and subsequent historic events (Gushue & Constantine, 2003). While research has shown that African Americans express both individualistic and collectivistic patterns, they tend to be more collectivistic in orientation (Baldwin & Hopkins, 1990; Gushue & Constantine, 2003). This is also supported by Petion et al. (2021), in which researchers found a qualitative theme of “collectivistic yet disconnected” amongst African American women, in which they feel a sense of close community amongst family members but often feel lonely when considering the quality of those relationships. Moreover, participants in the study expressed a desire to connect with other women experiencing the same phenomenon due to having participated in the study individually. Thus, a strong argument can be made for gathering a group of African American women whom all identify as having GT and helping to foster a space where they can explore the topic and begin to promote healing.

**Group Therapeutic Factors**

In addition to cultural and empirical support, another justification for employing group work as a disruptor of GT is the therapeutic factors of group processes: instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, and existential factors (Yalom & Leszcz, 2020). Each of these factors ties seamlessly into the epistemological, theoretical, and methodological frameworks of the study (to be discussed in the following chapter) and help underline the aims of the group portion of the
study as they relate to GT. The following paragraphs describe the significance of each of the group therapeutic factors as they relate to a GT group with MBW.

Installation of hope involves the group facilitator reinforcing positive expectations, correcting negative preconceptions, and explaining the potential healing properties of the group. Relevant to this study, group facilitators will explain the study’s rationale and how it was designed as a response to the findings and limitations of the Petion et al. (2021) study in which individually interviewed African American women expressed a desire to connect with other women who are also experiencing GT, in addition to having expressed significant, positive changes in their emotional and relational wellbeing as a result of participating in the study. This factor underlines the buy-in needed from participants for the goals of the study to be attained.

Universality is the common denominators between members of a group, despite their complex, human differences. While group members may share ethnic, gender, and age range/generation identities along with the phenomenon of GT, they will inevitably have some differing identities and experiences in their spiritual beliefs, family of origin dynamics, and developmental stages. As they learn about their similarities, they tend to benefit from the communal experience of working through a unique challenge with others who can relate.

Yalom and Leszcz (2020) state that the ideal context of a group is “one of partnership and collaboration” (p. 9). The therapeutic factor of imparting information, and the sub-factor of didactic instruction, relate closely to the principles of participatory action research in that individuals will learn from the information received (e.g., relational skill-building, conflict resolution, etc.), but they are also teaching others (including the group facilitators) by way of sharing their experiences and thoughts with the group. In this case, imparting and intaking information will go hand in hand. Correspondingly, altruism highlights the fact that groups are
the only modality of counseling that allows for the client or participant to be of benefit to others. As group members, they will shift between help receivers and help givers as they connect with peers and work towards a shared goal.

The most glaring therapeutic factor in relation to the topic of the study is the corrective recapitulation of the primary family group. By this, Yalom and Leszcz (2020) mean that the group setting can resemble a family in many ways (i.e., authority/parental figures, peer/sibling-type relationships, strong emotions, conflict, intimacy, competitive feelings, etc.). Eventually, members will interact with one another in a manner reminiscent of how they interact with their families. One of the goals of the group would then be to highlight these familiar reaction patterns and work to correct any maladaptive ones. Moreover, because GT may not be a common topic of discussion in their families, the group can be used as a productive space to develop socializing techniques and get interpersonal feedback related to the topic of GT. This allows individuals to learn how their intentions impact others in shared spaces. Relatedly, interpersonal learning as a group factor is described by the importance of interpersonal relationships, a corrective emotional experience, and the group as a social microcosm. Additionally, group cohesiveness is self-explanatory, with the multiple different relationships amongst group members in mind. However, a group need not be completely cohesive and conflict-free for members to benefit from it. In fact, groups that have some conflict and successfully work through it build on their cohesion to have corrective experiences, just as within other interpersonal relationships.

Lastly, the existential factors of a group are broken down into five items: (1) recognizing that life can be unfair and unjust at times; (2) recognizing that ultimately, there is no escape from life’s pain and death; (3) recognizing that no matter how close an individual may get to other people, they must face life alone; (4) facing basic issues of life and death, thus living more
honestly and being less caught up in trivialities; and (5) learning that an individual must take responsibility for their own life, no matter how much guidance and support are received from others. These existential factors are said to be the most important when taking what is gained from the group and applying it to ‘the outside world.’ This serves as additional evidence of the overlap between the cultural considerations of GT in MBW, the use of a group to facilitate generational healing, and the importance of an action-focused component that encourages participants to make some sort of positive change in their lives as it relates to GT. Participation in a GT group demonstrates a personal commitment to learning about GT and healing, and the group should foster a space in which participants are encouraged to apply what is learned in the group to ‘the outside world’ (i.e., their interpersonal relationships, families, and communities). This study’s main component is rooted in groupwork and guided by the participatory action research framework for the researcher-participant relationship to serve as a strong foundation on which participants can feel empowered to improve their circumstances surrounding GT.

Implications

Given the prevalence of trauma, generationally transmitted trauma, and its socio-behavioral and interpersonal effects, it is important to consider the presentation of GT in clinical practice. Additionally, it is essential that counselor preparation programs equip future counselors with evidence-based knowledge and skills to work with clients presenting with GT. Implications for clinical practice, counselor preparation, and future research are discussed.

Clinical Practice

Given the prevalence of trauma, professional counselors are extremely likely to encounter clients presenting with trauma- and stressor-related issues. Additionally, considering historical
and contemporary evidence of epigenetics, professional counselors are likely to encounter clients who are the offspring of individuals who experienced traumatic events (i.e., those impacted by GT). Clients could be presenting with an issue or set of symptoms that feel unique to them. Still, it is imperative for the clinician to conceptualize the client holistically, including generational and historical effects of trauma. This might mean utilizing psychoeducation to inform the client about what they may be experiencing. It may also look like seeking adjunct services for the client to connect to, such as group counseling or support group spaces where they can connect with others going through similar experiences. Additional research is needed to investigate the efficacy of group work with this population. With the potential findings in mind, clinicians may have a better understanding of presentations of trauma and GT, resulting in them being able to accurately identify it, reducing instances of under-, over-, or misdiagnosis of TSRDs in African Americans. Additionally, they will gain further information about how to facilitate treatment of GT in African American clients, including adjunctive therapies and approaches to traditional counseling. Furthermore, the ethical standards of the counseling profession state: “when providing services, counselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation” (American Counseling Association, 2014, p. 10). Professional counselors are ethically obligated to seek out empirically supported treatments and modalities for their clients. This study could contribute to the minimal body of literature that provides empirically supported treatments for GT in African Americans.

**Counselor Preparation**

As of 2021, courses in crisis and trauma intervention are still not a requirement within graduate-level counseling training programs, despite the growing prevalence of clients presenting to mental health services reporting a history and/or presence of trauma (Breslau &
Kessler, 2001; Council for Accreditation of Counseling and Related Educational Programs, 2016). If the accrediting body of the counseling profession fails to send the message that trauma is essential to study and gain competence in, this makes it difficult for counselor educators to relay that message to counselors in training. As a result, there could be an influx of emerging counselors entering the profession ill-prepared to treat a prevalent issue that many clients will present with. This has widespread implications for minority mental healthcare and previously discussed disparities in public health outcomes.

**Future Research**

Future research is needed to understand millennial Black women and their experiences of GT. Future studies may want to (a) better understand how MBW experience and perceive GT within their families of origin; (b) equip MBW with resources, skill-building opportunities, and the communal support needed to address GT within their families; and (c) investigate the impact of participating in a structured support group on MBW’s understanding and self-efficacy of addressing GT within their families.

**Conclusion**

While much is known about trauma at large, there is more to be explored about the lasting and transferrable effects of trauma across time and generations. GT affects the psyches of individuals, which in turn impacts their interpersonal relationships, including family and community dynamics. Further, there is much to be understood about specific populations to whom GT is most relevant, such as African Americans and African American women, and even more about processes for addressing and healing GT within families and communities. While this chapter laid the groundwork for existing and ensuing GT literature, the following chapter
focuses on the details of an empirical study that aims to examine practical and culturally-appropriate routes for generational healing.
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2 PROJECT HEAL GENERATIONAL TRAUMA: A MIXED METHODS PARTICIPATORY ACTION RESEARCH INVESTIGATION OF GENERATIONAL TRAUMA AND HEALING IN MILLENNIAL BLACK WOMEN

In the United States, 61% of men and 51% of women report exposure to at least one traumatic event in their lifetime, and 90% of clients in public behavioral health care settings report having experienced some form of trauma (Substance Abuse Mental Health Services Administration [SAMHSA], 2022). Trauma is “an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and has adverse effects on the individual’s functioning” (SAMHSA, 2022, para. 2). Persons with trauma experience have adverse biological outcomes (e.g., poorer physical health, sickness, restlessness or insomnia, changes in appetite or weight), mental/emotional symptoms (e.g., flashbacks, avoidance, anxiety, depression, substance abuse, anger, suicidal ideation, poor concentration), and relational challenges (e.g., irritability, grief, isolation, difficulty in work or school) (SAMHSA, 2022). Much attention has been given to examining whether or not these effects are lasting (i.e., passed down from parent to child) or if they dissolve over time or with treatment. Results are equivocal, and it is currently unclear whether nature or nurture prevails within generational trauma (McEwen, 2012). Instead, there is an argument that biological, physiological, social, and environmental factors contribute to transgenerational processes.

Generational Trauma

Generational trauma, intergenerational trauma, transgenerational trauma, and historical trauma are terms that have been used interchangeably and describe how trauma from one generation can affect future generations (Conching & Thayer, 2019). For the purpose of this study, the term ‘generational trauma’ (GT) is used to describe trauma and the effects of
trauma that are passed down from generation to generation within families. The study of GT emerged in the 1960s as behavioral health professionals first noticed an influx of children of Holocaust survivors seeking psychotherapy treatment (Matz et al., 2015). Acknowledging an individual need not be present at the time of a traumatic event to be affected by it led to a better understanding of the marked differences between these children of Holocaust survivors and the general population.

Similarly, the concept of “historical disenfranchised grief” was introduced to describe the ‘social pathology’ among Native Americans, including suicide, homicide, domestic violence, child abuse, alcoholism, and other social problems by Brave Heart and DeBruyn (1998). Historical, social, and political forces were identified as agents who aided the passing of these ‘social pathologies’ from generation to generation. As Europeans forcefully took over Native American lands, including plants and animals that were considered sacred relatives to them, the loss they experienced became a source of collective grief. Additionally, the forced social changes Native Americans experienced, such as waves of disease and genocide, the boarding school era, and federal assimilation policies, contributed to the disruption of their culture and the intensification of “normative emotional reactions” (p. 67) such as anger, guilt, and sadness that permeate families, communities, and generations. These untreated normative emotional reactions resulted in maladaptive coping strategies as survival mechanisms for enduring continued disenfranchisement and harmful external forces for Native Americans.

While GT has been studied for nearly sixty years in populations such as Holocaust survivors, Indigenous groups, Vietnam veterans, and survivors of domestic violence (Mangassarian, 2016; Marsh et al., 2015, 2018; Matz et al., 2015), there remains a dearth of the empirical literature with regard to how present-day African Americans experience GT
within familial contexts as a result of race-based traumatic stress in the United States, and little is known about the mental health and wellness ramifications of this phenomenon.

**Generational Trauma in Black Communities**

Over 41 million Black and African American individuals make up 13.4% of the United States population (*U.S. Census Bureau QuickFacts*, 2021). (The term ‘Black’ denotes individuals of African descent across the diaspora, including African Americans. For the purpose of this study, the terms ‘Black’, ‘Black American,’ and ‘African American’ will be used to describe individuals of African descent living in the U.S.) Despite this number, Black Americans account for 38.3% of U.S. prison inmates (Federal Bureau of Prisons, 2022). Moreover, according to the National Center for Education Statistics (de Brey et al., 2019), Black children make up 31% of all children living in poverty in the U.S. Public health disparities are exacerbated within African American communities. African Americans ages 18 to 49 are twice as likely to die from heart disease than their White counterparts, and African Americans ages 35 to 64 are 50% more likely to have a high blood pressure than their White counterparts (CDC, 2020). Black Americans have also been disproportionately affected by the COVID-19 pandemic, experiencing higher rates of hospitalization and mortality (Novacek et al., 2020; Yancy, 2020). As such, increasing mental health risks in Black communities are of particular interest, including loss and grief, depressive symptoms, PTSD symptomology, and social isolation (Novacek et al., 2020; Yancy, 2020). Given this array of social, educational, and physical disparities against African Americans, transgenerational processes continue to contribute to these disparities on all levels.

Various terms are used to describe the multigenerational effects of trauma on African Americans. “Post-traumatic slave syndrome (PTSS),” a play on the Diagnostic and Statistical
Manual-V disorder of post-traumatic stress disorder (PTSD), has been used to explicate the multigenerational transmission of trauma. PTSD symptoms align with how the effects of slavery emerge in African Americans today as PTSS (DeGruy, 2017). “Residual effects of slavery” (RES) has been used to describe the racist treatment of African Americans during and after slavery and the impact on multiple generations of African Americans (Wilkins et al., 2013). One typical example of RES includes the infliction of dangerous, oppressive conditions within the African American family home in an attempt to foster the successful socialization of children into the majority culture. On the other hand, GT has been argued as a cultural trauma in which the trauma in question is not slavery as an institution or a personal experience but rather a collective memory and a pervasive foundation for African Americans’ sense of self (Eyerman, 2001). From this perspective, GT is rooted in identity formation, which impacts generational conflicts. Failure to consider how the enslavement of Africans as well as other historical traumas (e.g., Jim Crow, the Civil Rights Movement, police brutality, etc.) affect aspects of present-day African Americans’ experiences and presenting problems in counseling may lead professional counselors to conceptualize cases from a perspective that is not representative of African Americans’ uniqueness. Subsequently, this cultural encapsulation can lead to ineffective treatment and harm to clients (Wilkins et al., 2013). Thus, developing more empirical understandings of African Americans’ lived experiences of GT serve as a needed next step to facilitate effective treatment and true healing.

**Generational Trauma in Black Women**

Each African American woman holds a minimum of two intersecting, marginalized identities, resulting in a cross between race- and gender-based violence, discrimination, and oppressive forces. Black girls make up one-third of the girls referred to law enforcement by
U.S. public schools, and over 40% of girls are arrested in connection to a school incident (DuMonthier et al., 2020). Black girls ages 18 to 19 are four times more likely to be imprisoned than White girls (DuMonthier et al., 2020). Regarding higher education and pay, Black women only make up 11.4% of total bachelor’s degrees earned by women in the U.S., and they only earn 62 cents for every dollar earned by their White male counterparts (Women of Color in the United States (Quick Take), 2022). DuMonthier and colleagues (2020) found that Black women face higher rates of intimate partner violence, rape, and homicide than other races of women. Additionally, several studies have revealed gender differences in response to GT, including possessing a greater degree of conscious affective experiences (Brave Heart, 1999), struggling to maintain the “Strong Black Woman” syndrome or trope (Beauboeuf-Lafontant, 2009), and balancing both the strength associated with masculinity and the vulnerability associated with femininity (Evans et al., 2017). Moreover, we acknowledge the unparalleled plight of African American women in the Black family system since the start of American slavery: mothering, lack of privilege, sexual exploitation, civil rights fights, and more. For these reasons, we focus on the African American woman and aim to explore GT from her perspective. This study aims to understand better how millennial Black women (MBW) perceive and experience GT within their families of origin and understand the impact of participating in a support group on MBW’s self-efficacy in addressing GT within their families. The research questions, data sources, and methods of analysis include:

(1) How do MBW experience and perceive familial GT throughout participation in a GT support group?

a. Data sources:

i. Individual and focus group interviews
ii. Group dialogue

b. Method of analysis:
   i. Critical discourse analysis

(2) What is the relationship between participation in a GT support group and self-efficacy in addressing GT within the family of origin among MBW?

a. Data sources:
   i. The New General Self-Efficacy Scale (NGSE)
   ii. Individual and focus group interviews

b. Method of analysis:
   i. Dependent t-test
   ii. Critical discourse analysis

**Study Framework**

Methodology, according to (Schwandt & Gates, 2017), is “the study of how a particular kind of investigation should proceed” (p. 341) and philosophically examines suppositions, principles, and the subsequent justification of methods and techniques associated with a specific approach. The methodological framework for this study includes Black feminist epistemology, critical theoretical perspective, participatory action research paradigm, interview, focus group, measures of trauma and self-efficacy, and discourse analysis.

**Black Feminist Epistemology (BFE)**

Epistemology provides standards for what is considered knowledge, how it is constructed, and why we believe what is believed to be true (Eyerman, 2001). As such, power dynamics govern these epistemological processes, shaping who is believed and why. In the U.S., elite White men tend to control the Western structures of knowledge, and their interests, biases,
and experiences permeate the epistemologies of traditional scholarship. Consequently, Black women’s experiences have historically been distorted or wholly excluded from what is considered knowledge. Within this Eurocentric context, Black feminist thought has been wrongfully labeled as a form of subjugated knowledge or inadequate or subpar knowledge compared to other, more widely accepted epistemologies. This led African American women to utilize alternative methods of knowledge foundation such as “music, literature, daily conversations, and everyday behavior” (p. 270) as fundamental sites for constructing knowledge on their lived experiences. Given that the participants of this study were Black women, it is essential to center this intersectional identity in the research. BFE is a field of knowledge focused on the perspectives and experiences of Black women, considering intersecting identities, and includes the following tenets: (a) lived experience as a criterion of meaning; (b) the use of dialogue in assessing knowledge claims; (c) the ethic of caring; (d) the ethic of personal accountability; and (e) Black women as agents of knowledge.

BFE values the importance of first-hand wisdom and lived experiences as opposed to listening to those who merely read or thought about what an outsider may claim to know. (Hill Collins (2009) asserts there are two types of knowing: knowledge and wisdom. These two types of knowledge can be analogized as what some may colloquially call ‘book smarts’ and ‘street smarts,’ respectively. While the former requires a specific cognitive and intellectual capability, the latter requires a particular socioemotional ability to maneuver through societal structures such as the intersecting oppressions of racism and sexism, which has been essential to the survival of African American women. BFE seeks to challenge the idea that formal education and Western epistemologies are the only routes to pursue knowledge.
The second tenet of BFE, the use of dialogue in assessing knowledge claims, is based on the fact that dialogue occurs between two or more subjects, and there is no speech of subject and object. Essentially, one cannot establish new knowledge claims on their own, but they must be engaged in dialogue with other members of a community to make such claims. This belief in connectedness in the use of dialogue is rooted in African-based oral traditions and culture. Therefore, this study utilized a participatory action-based group paradigm to foster dialogue amongst MBW on GT; richer claims can be drawn from parallel dialogue than individual interviewing alone (i.e., subject and object).

The third tenet of BFE is the ethics of caring as “ideas cannot be divorced from the individuals who create and share them” (p. 281), or personal experiences, emotions, and empathy are central to the knowledge construction process. Each individual exhibits a unique expression of “a common spirit, power, or energy inherent in all life” (p. 282) despite a communal culture. Hill Collins (2009) compared this idea to that of a quilt, in which each square has unique qualities, but each of them comes together is needed for a functional, cohesive quilt. The ethics of caring includes emotion as a key communicator in dialogues. Contrary to more Western ideologies where emotional expressions may be pathologized and discounted, emotions are viewed as indicators that the speaker believes in the validity of an argument in BFE. This is reflected in African-centered music, literature, and daily conversations. The third component of the ethics of caring tenet is developing the capacity for empathy because without individuals’ empathy; it would be difficult for persons to engage in meaningful dialogue with one another.

The ethic of personal accountability is the fourth tenet of BFE, whereby individuals must be accountable for their knowledge claims. Not only must they identify with the experiences of Black women, be engaged in dialogue with other Black women, and carry a personal ethic of
caring, but they must also be respected for the moral and ethical connections to the ideas they share. With this, their thoughts will carry more weight than those who may lack a level of accountability.

The final tenet of BFE, Black women as agents of knowledge, is directly connected to the basis of BFE: that Black women’s experiences are valued as truth and that they should speak for themselves. Black women must be advocates for themselves, willing to share their narratives and knowledge claims, and engage in meaningful dialogue with others about their work. Historically, this context has always existed because Black women intellectuals existing within Western spaces have always been governed by external knowledge validation processes that may be the antithesis of everything that BFE stands for. However, despite these challenges, Black women intellectuals and advocates have continued to pave the way for continued knowledge construction surrounding their experiences. This study aims to build upon and contribute to that. Through these tenets, GT was explored from the pillars of lived experiences and dialogue amongst Black women, providing a space for Black women to learn about and take accountability for their role in their family’s GT through caring and ultimately honoring the voices and experiences of Black women as truth. Through these components, the construction of knowledge was conceptualized based on what occurred within this study.

**Critical Theoretical Perspective**

While the epistemological stance focuses on *how* knowledge is claimed, a theoretical perspective justifies *why* that knowledge is claimed. In other words, theoretical perspectives seek to justify, or an underlying purpose for, the work done. This study took on a critical theoretical perspective in that it sought to bring about change rather than research that merely seeks to understand (Crotty, 1998). An additional feature of the critical theoretical perspective is that it
sought to challenge exploitation, oppression, and other forms of injustice to liberate or emancipate those harmed. Given that this study was not simply extracting information from participants but seeking to empower them with tools for addressing GT in their families, the study's perspective and goals were directly aligned. Because the theoretical perspective is so closely related to the participatory action research paradigm, more about the emancipatory nature of the study is explained in the following section. In the data collection and analysis sections, the researchers discuss a critical take on positivism and quantitative analysis.

**Participatory Action Research (PAR) Paradigm**

While PAR is typically associated with constructivism and phenomenology based on lived experiences, PAR is rooted in BFE and critical perspectives for this study as the goals are comparable. PAR seeks to “understand and improve the world by changing it” (Baum et al., 2006, p. 854). The PAR paradigm typically draws on critical theories and tends to use a range of qualitative and quantitative methods of inquiry to improve the lives of participants by involving individuals who, in turn, will take action to improve their own lives.

Action research, at its core, is meant to “connect science and society” (Eikland, 2015, p. 386). There must be some understanding of their real-life experiences and how those shape the world in which they live. Additionally, the researchers’ own experiences and understandings do not exist in isolation; they also affect the scientific inquiry process, whether intentional or unintentional. For instance, scientific inquiry is not the sole prerogative of researchers. There is much to be gained beyond the knowledge that is constructed from scientific findings, such as improving the lives of participants. When researchers interact closely with non-researchers, it is a win-win situation as both parties gain something from the experience that can enhance their wellbeing and relationships. However, no inquiry can eliminate all social problems. The inquiry
process involves both qualitative and quantitative methods and must incorporate the workings of human emotion and relations, which are aligned to the tenets mentioned above of BFE. The PAR acronym contains three pillars that each speak to a critical component of this paradigm of inquiry: (a) participation or life in society; (b) action, or experience and practice; and (c) research or knowledge-making. While PAR does not claim to be a monolithic paradigm, each inquiry may take on varying combinations of these three pillars.

**Participation**

The level of participation of both researcher and participants is often the most debated pillar of the PAR paradigm (Chevalier & Buckles, 2019). The ‘P’ in PAR is typically defined in one of two ways: (1) participants take part equally in all project activities, making them ‘co-researchers’ who share power equally with the researchers and collaborate on decisions throughout the inquiry process; or (2) participants ‘partner’ in that they make “distinct, complementary, and closely coordinated contributions” (p. 25) to achieving the shared goals of the study. The first option would require researchers to take a ‘backseat’ to the community and allow it to run itself, providing minimal structure and guidelines for the process, in which they would need to have a firm understanding of the method of inquiry to ensure that the goals of the study are reached. The second option is a more semi-structured approach in which partners have a significant stake in the research process but are not expected to lead or guide the way (this would be the responsibility of the researchers). The participants in this study fell in the middle of the two definitions above. Due to the sensitive and complex nature of the phenomenon at hand (i.e., GT) along with the time constraint of the study, they took on a ‘member’ participation style in which they informed decision-making on group processes but were not expected to contribute significantly to the data collection or analysis processes. This nomenclature of “group members”
was organically decided upon by the group members and indicated that they are active members of the research process. From this point forward, participants will be referred to as “group members” or simply “members.”

**Action**

Chevalier and Buckles (2019) caution researchers against watering down the ‘A’ for ‘action’ in PAR to a simple ‘potential for action’ in which members are simply made aware of what change is possible. The ‘action’ is merely ‘pregnant’ and has not ‘given birth.’ For the action to ‘give birth,’ members must act on their newly gained awareness of the problems they face towards the future that they want for themselves throughout participation in the study. Additionally, the action piece of the study must be justice-oriented in that it addresses power structures such as exploitation and oppression, specifically gendered racism, as it relates to Black women’s unique lived experiences (Stanton, 2014).

**Research**

Action inquiry is not to be confused with action research (Chevalier & Buckles, 2019). The two have different intentions and tasks in order to reach a goal. What distinguishes action research from action inquiry is that it meets standards of rigor and is designed to advance general knowledge. PAR discussions often refer to researchers’ epistemological stance of choice to determine how those two requirements should be met. As such, rigor and the advancement of knowledge are determined by the foundation of lived experiences as criteria of meaning, the use of dialogue in assessing knowledge claims, the ethics of caring and personal accountability, and staying true to Black women as agents of knowledge. With the underpinning of each of these BFE tenets, this PAR study has met standards for rigorous research with new knowledge claims.

**Mixed Methods Design**
For the purpose of this study, a mixed-methods design is defined as an intersectional blend of both qualitative and quantitative methods. Regarding the intersectionality of both methods, the sum of the entire study is more than just performing a quantitative study, performing a separate qualitative study, and then joining them together in the writing process. Both parts were inextricably linked to the other throughout the research process. For example, the MBW who participated in this study were likely unable to describe their experiences as a Black person without also considering how being a woman impacted their experiences. Similarly, this study embodied mixed methods research in that the quantitative pieces informed the qualitative pieces, and the qualitative pieces informed the quantitative pieces. Members completed measures and participated in individual interviews before starting the support group. They were prompted to dialogue about how they perceived their quantitative survey results to fit (or not to fit with) their narrative and lived experiences. In turn, the information gathered from the group dialogue influenced how members responded to the post-surveys. Individual and group data were used to inform the facilitation of the group, including topics and tools provided.

Because this study employed qualitative and quantitative data sources under a mixed-methods design, we must also discuss the opposing epistemological stances of these two seemingly different approaches to research. While the epistemological stance of the study is BFE, which falls under the lens of constructivism, the more quantitative components of the study lend themselves to being more positivist. Positivism is the “objective” view that objects and experiences have meaning before, and independently of, any consciousness of them (Crotty, 1998, p. 27). On the other hand, constructivism purports that human consciousness is what gives objects and experiences their meaning. However, there is a growing sector of the mixed-methods research community in which qualitative and quantitative research are viewed less as binary
opposites, instead opting to acknowledge the methodological diversity in each of them (Giddings, 2006). As such, rather than forcefully choosing the epistemological stance of either the quantitative or qualitative paradigms, mixed methods researchers position themselves under the movement of pragmatic research or research that seeks to apply designs that are the best fit for finding the answers to the questions of interest (Giddings, 2006; Hesse-Biber, 2010).

The essence of pragmatic research and its emphasis on working backward from the questions of interest led me to consider a more transformative approach to research, or one that seeks to enhance social justice, the advancement of human rights, and the acknowledgment of cultural norms (Mertens, 2010). It is also evident how this transformative, pragmatic approach to the research questions seamlessly overlaps with the PAR paradigm of the research study. Action-and justice-oriented elements were the primary goal of the study as they related to members’ experiences, and it is also evident in the framework of the study in terms of what was expected of the research process (i.e., sources of knowledge, projected findings, etc.).

Some critics of mixed methods research claim that much of it succumbs to the traditional views of positivism or takes the stance that there is an objective truth to be discovered through mixed methods research (Giddings, 2006). To avoid such a fault, this study took on an iterative sequential mixed methods design (quan → QUAL → quan → QUAL). Quantitative data was collected initially, and those preliminary findings were used to inform the support group curriculum (which informed the group’s weekly dialogue). Additional quantitative data was collected at the end of the group for individualized discussions about the pre-post scores compared to one another. Final inferences were made based on both qualitative and quantitative strands of the study in conjunction with one another. The qualitative data was prioritized because members’ descriptions of their lived experiences are valued more than numerical evaluations of
measures. Due to the study’s design, the results were derived from members’ voices and narratives.

Roles

Given the PAR-based collaborative nature of the study, the roles of the research team, including members and researchers, are outlined. In addition, the positionality of the primary researcher is discussed as ethical caretaking.

Participants as Members

Criteria for eligibility to participate included: (1) self-identify as Black, African American, or having African ancestry; (2) self-identify as a cisgender or transgender woman; (3) born between 1981 and 1996; (4) identify as currently experiencing familial GT; (5) can access Zoom with a strong internet connection in a private setting; and (6) commit to participating in each phase of the study. Commitment to the study involved taking appropriate measures, participating in all interviews and group meetings, and engaging in the research process by sharing feedback with the group about process observations and preliminary analyses.

There were 15 MBW who initially committed to participating in the study. Within the first two weeks of the group, three members dropped out due to personal reasons (i.e., unexpected death in the family, scheduling issues, and absences). Thus, 12 members made up the final group. Group members’ ages ranged from 26 to 40 (M = 29.83, SD = 4.51). Although all the group members identified as Black, we acknowledge that Blackness is not a monolith. Therefore, we sought to learn about their unique ethnic identities. Ethnic identities of the group members included African American (n = 8), African American and Caribbean American (n = 2), African American and African (n = 1), and African American and Hispanic (n = 1). The majority of them identified as Christian (n = 8), while others identified as Agnostic (n = 2), or
“nonreligious/spiritual” \((n = 2)\). Group members’ current geographic regions spanned across four geographic regions in the continental United States: Southeast \((n = 5)\), West \((n = 4)\), Southwest \((n = 2)\), and Northeast \((n = 1)\). The group operated across four time zones. The group was also highly educated, with the representation of a doctoral degree \((n = 1)\), master’s degrees \((n = 7)\), and bachelor’s degrees \((n = 4)\). Additionally, three of the four bachelor’s degree holders reported being enrolled in a master’s program. Half the group members identified as either a mental health professional (MHP) or an MHP-in-training (i.e., psychologist, marriage and family therapist, and university instructor). Other group members’ professions included public health, neurobiology, elementary education, nonprofit management, and a homemaker. One group member reported currently seeking employment. Relationship statuses of the group members included: single never married \((n = 5)\), in a committed relationship \((n = 3)\), married \((n = 2)\), and divorced \((n = 1)\). One group member was engaged to be married at the start of the group and married during the course of the group. Most group members did not have children \((n = 8)\), while three reported having one child. One group member reported having two children, one of whom is deceased. Despite the focus on MBW, the group displayed diversity across age, ethnic identity experiences, religious and spiritual beliefs, and relationship and parenting experiences. A summary of group members’ demographics is presented in Table 1.

**Research Team**

The research team comprised two support group co-facilitators and one process observer. Each of the research team members identifies as MBW with GT. Additional details about their roles are detailed below.

**Support Group Co-Facilitators**
Support group co-facilitators were comprised of myself and another individual. I am a doctoral candidate and the student principal investigator of this study. The other co-facilitator was a master’s student intern in clinical mental health counseling who earned her master’s degree and began a doctoral program in counselor education and supervision halfway through the support group meetings. The co-facilitators met weekly to discuss preparation for each group meeting and any concerns about individual members or the group as a whole. Prior to each group meeting, the duties for each week’s curriculum were divvied amongst the two facilitators equally (i.e., deciding who would facilitate which activities and discussions). However, the facilitators remained flexible in that each chimed in to help facilitate the group dialogue even if the lead was not assigned. The co-facilitators also debriefed after each group meeting for about 30 minutes to discuss any member or group concerns, countertransference, and personal biases or judgments.

**Support Group Process Observer**

The support group process observer was a doctoral student in counselor education and practice who earned candidacy status during the support group meetings. Due to scheduling conflicts, she could not attend the support group meetings in real time. The recordings were shared with her, and she provided written process observations that were shared with the facilitators before the following group meeting. She could log onto one meeting for about ten minutes to formally introduce herself and meet the group members “face to face.” The group members appreciated being able to “put a face with the name” behind the weekly process observation notes and discussions. Process observations averaged about one to two typewritten pages, double spaced. The facilitators deidentified and summarized the process observations and shared them with the group members towards the start of each meeting.
Members were engaged in dialogue about the observations, including thoughts of agreement, disagreement, or added depth.

**Researcher Positionality and Reflexivity**

To discuss researcher positionality throughout this research study, I abided by the standards of Pillow (2003): (a) growing beyond the relationship of the researcher to the data, (b) examining and discussing positionality throughout the entire research process, and (c) welcoming and normalizing discomfort in the process. I also acknowledge that while the dissertation is a solo project, I still had to guide the research assistants and members through this process as the student principal investigator. My understanding of positionality is that it is to be considered throughout the entire study, from the brainstorming phase through the data collection and analysis phases to the writing phase, and even when considering future research studies that may build off of the findings from this one.

I, the primary researcher, identify as a Black/African American cis-gender woman with Caribbean heritage. I also identify as having experienced various forms of historical and cultural trauma on a larger scale (e.g., residual effects of slavery, vicarious trauma from witnessing police brutality and lynching), and GT within my family of origin. Additionally, I am a licensed associate professional counselor holding a bachelor’s and a master’s degree in psychology and clinical mental health counseling, respectively. I am also completing a doctoral degree in counselor education and practice and thus have extensive education, training, and clinical experiences related to the topic of this research study. Moreover, I have conducted several therapeutic groups in community, clinical, and academic settings, many of them being people of color, in which the topic of GT emerged.
Given my personal and professional connections to the topic, it is necessary to discuss how subjectivities were managed throughout the study: the use of a research team, bracketing, and member checking. From the recruitment phase through the writing phase, I was accompanied by a team of two research assistants. The research team was representative of the group members based on race and gender (i.e., they were also MBW). They also both identified as having familial GT. One research assistant was a doctoral student and licensed associate professional counselor. The other was a master’s student who graduated and began a doctoral program in counselor education during the group. Given the varying yet similar identities, the research team engaged in bracketing throughout the research process. With some shared identities and intentional efforts to check biases, the perspectives of the group members remained at the forefront of the study. For example, after each support group meeting, the research team met to debrief and discuss any personal subjectivities or biases that emerged from what was shared by others. The team was also encouraged to hold one another accountable for biases that may be implicit or not yet brought to awareness. For example, one researcher shared their perspective on a group dynamic, and another researcher asked, “How is your perspective impacted by XYZ bias/lived experience you shared with us?” (XYZ, being something personal the original researcher shared related to their own experiences with, or biases of, generational trauma).

The researchers also facilitated member checking throughout the process to ensure that the members’ experiences were accurately collected, analyzed, and presented. Given the PAR paradigm of the study, members were naturally involved throughout the research process, more than typical participants. With regard to data collection, the research team regularly requested feedback from the members about topics to discuss and the overall facilitation style of the group.
For example, the process observer provided written notes after each session, and the members were given space to confirm or refute the observations or make general comments about them. With this feedback, co-facilitators made changes in real-time to be responsive to the needs of the members.

Additionally, this feedback allowed the researchers to understand the experiences of the members better, and this helped to develop the codes that revealed themes in their interactions more accurately. Also, members’ engagement and feedback determined the course of the group, which ultimately determined the capacity of the results. Regarding data analysis, the research team shared the preliminary themes developed based on the group meetings with each member in the post-individual interviews. Members stated agreement with or opposition to themes that were found, and they were prompted to share honest feedback. With regard to the manuscript writing phase, members’ quotes were presented anonymously, and they were given a copy of the final draft of the dissertation manuscript for their edification. This step ensured that the members felt their experiences were accurately represented.

**Procedures**

**Timeline**

IRB approval was granted in March 2022, and recruitment began shortly after. The initial interviews started in late March 2022, and the weekly support group was facilitated from April 6, 2022, to May 25, 2022. Members’ commitment spanned ten weeks, including one pre-individual interview and survey, eight weeks of support group meetings (with the mid-point focus group), and one post-individual interview and survey. Overall, members’ participation spanned from March 2022 through May 2022. A table detailing the timeline of the study is presented in Table 2.
Recruitment

A purposive recruitment technique was used to obtain a sample for this research study. Members were recruited via social media, professional networking groups, and word of mouth using a flyer (see Appendix A). Since millennials range from 25 to 40 years, most may not be on college campuses. Thus, relying on social media, professional networking groups, and word of mouth happened to be more advantageous and yielding a diverse sample.

Sampling

The initial survey received a total of 31 responses in two days. To ensure equity and fairness in the sampling process, we followed up the purposive recruitment techniques with a convenience sampling technique. Upon completing the initial survey, the first 15 individuals were contacted via email and given one week to sign up for their pre-individual interview; the other 16 individuals were placed on a waitlist. If there was no response from the first 15 individuals, or they failed to show up for their scheduled pre-individual interview, individuals were moved off the waitlist and contacted via email to sign up for their pre-individual interview. This process was repeated until 15 individuals completed the pre-individual interview and verbally consented to participate in the group. The remaining waitlisted individuals were informed that the group was filled and were given resources for mental health support. This equitable, ‘first-come, first-served style of sampling is consistent with the social justice orientation of the research framework.

Data Collection

Data sources included a demographic questionnaire, two instruments (i.e., Trauma History Questionnaire and New General Self-Efficacy Scale), pre-individual interviews, support group meetings, mid-point focus group interviews, and post-individual interviews.
**Demographic Questionnaire**

The demographic questionnaire inquired about aspects of prospective members’ cultural identities (i.e., race, ethnicity, gender, age, religious and spiritual identity, occupation, annual income, birthplace/nationality, etc.). It also prompted them to share brief statements about the dynamics of their families of origin. The demographic survey also included a request for contact information (i.e., phone and email address) for them to be contacted throughout the study.

**Trauma History Questionnaire (THQ)**

THQ is a 24-item self-report measure that examines experiences with potentially traumatic events using a yes/no format (Hooper et al., 2011). The range of traumatic events covered by the THQ mirrors the criterion of a DSM-5 diagnosis of posttraumatic stress disorder (PTSD) (e.g., crime-related events, disaster, grief, and unwanted physical and sexual experiences). When an individual selects ‘yes’ to an event they have experienced, they are prompted to provide the frequency of the event and their age at the time of the event. Sample questions included, “Has anyone ever attempted to or succeeded in breaking into your home while you were there?” and “Have you ever received news of a serious injury, life-threatening illness, or unexpected death of someone close to you?” In the final section, individuals reported instances of GT, historical trauma, or other culturally significant items that the more general questions may not have covered. Because a formal assessment for GT does not yet exist, we drew from a clinical questionnaire developed by a licensed psychologist to self-evaluate exposure to GT (Braman, 2020). Sample questions included, “Has anyone in three generations of your family lost a significant piece of their cultural heritage due to genocide, slavery, or other forceful means?” and “Has anyone in three generations of your family experienced addiction or
substance misuse?” (See Appendix B for a complete list of THQ items.) The THQ takes approximately 10 to 15 minutes to complete.

The initial THQ study was conducted and normed on college student women in the year 2000 (Hooper et al., 2011). This means that the participants for this study would be at the higher end of the millennial age range, granted they were traditional college students. Stability coefficients ranged from .51 to .91, and moderate to high test-retest reliability was found as well (Hooper et al., 2011). Although the stability coefficient is slightly low, this is included as one of the limitations of the study. The purpose of the THQ in this study is to individually assess members for trauma and related symptoms prior to the start of the support group as a form of screening. It also served as priming for group members to begin thinking about their GT experiences within the context of their own traumatic experiences and their family dynamics, and it was only taken at the start of the study. The THQ demonstrated sufficient content and construct validity. Its cultural validity was primarily based on it having been translated into other languages (i.e., Spanish, Portuguese, Hebrew, French, Japanese, Kurdish, and Vietnamese). The authors even discuss how different genders may interpret items such as “attempted rape.” However, there is minimal mention of racial or ethnic diversity or other cultural identities relevant to trauma screening. Other limitations of the THQ include memory or motivational factors that may impact the accurate self-reporting (Hooper et al., 2011). Since its creation, the THQ has been used and adapted to assess various populations such as homeless people with severe mental illness, Brazilians with PTSD, medical help-seeking groups, and males in a high-security forensic inpatient setting (Fiszman et al., 2005; Gilmoor et al., 2021; McKenna et al., 2019; Rosenberg et al., 2000).

**New General Self-Efficacy Scale (NGSE)**
NGSE is an 8-item self-report measure that examines an individual’s perceived self-efficacy (Chen et al., 2001). It was initially conducted and normed on undergraduate students, the majority of them female. It demonstrated high construct validity and a moderate to high internal consistency reliability (.76 to .89). Stable test-retest coefficients were also found ($r = .67-.74$). Additionally, it was found to have predicted specific self-efficacy for various tasks in several different contexts, making it appropriately applicable to this study’s exploration of self-efficacy with MBW addressing familial GT. For example, the NGSE was found to positively correlate with several achievement-related demographic variables such as military rank and educational level, indicating a high predictive validity (Ben-Ami et al., 2014; Chen et al., 2001; Judge et al., 1998). Sample items of the NGSE include, “In general, I think that I can obtain outcomes that are important to me,” and, “I am confident that I can perform effectively on many different tasks.” (See Appendix C for a full list of NGSE items.)

Criticisms of the NGSE include whether or not the concept of general self-efficacy is a separate construct from self-esteem (Bong & Clark, 1999; Bong & Skaalvik, 2002; Chen et al., 2001, 2004). For instance, the authors discussed the difference between situational confidence in a person’s ability to achieve a task versus their overall confidence, personality, and approach to life. For this study, the differences in those constructs are not as important as understanding members’ general confidence with addressing GT within their families because the prompt was modified to gear members’ responses towards their self-efficacy with addressing GT. Overall, general self-efficacy has been conceptualized as a stable, trait-like construct. Thus, its exploration in the context of members’ participation in this study will be notable, despite whether or not their self-efficacy changes over the course of the study.

*Pre-Individual Interviews*
Initial interview protocol sections are as follows: (a) general demographic, identity, and family of origin information, (b) pre-survey results report and discussion, (c) GT experiences and perspectives, and (d) hopes and fears for the support group. Interviews lasted for about one hour each, and all members were interviewed prior to the start of the group. Interviews were audio-recorded and transcribed for analysis. Each member’s pre-individual interview responses were utilized to help construct the curriculum for the first two meetings of the support group to ensure that it was reflective of the needs of the members of the group. Sample questions from the pre-individual interview include, “What motivated you to join the group?” and “What are you hoping to gain from this group? From other group members? For yourself?” (See Appendix D for the pre-individual interview protocol.)

**Support Group Meetings**

Support group meetings occurred once per week, for one hour, for eight consecutive weeks on the Zoom virtual meeting platform. Each of the eight support group meetings was recorded and transcribed for analysis. Two group facilitators led the support group meetings. Each meeting was used to determine the agenda for the following meeting to best meet the unique needs of the group members. Meeting agendas were structured by a brief check-in activity, followed by the main activity or discussion, and brief check-out activity. Any homework assignments, or tasks for the members to complete between meetings, were explained towards the end of each group. (See Appendix E for the support group curriculum, including details of each support group meeting.)

**Mid-Point Focus Group Interviews**

Mid-point focus group interviews (between-group meetings four and five) comprised four members and one facilitator. They focused on the following topics: (a) general reflections, new
knowledge, and comments about the group so far, (b) revisiting hopes and fears from the pre-individual interview, and (c) constructive comments for the research team. The purpose of the focus group interviews was to meet with the members more closely (i.e., in groups of four rather than the entire group of twelve), gauge their levels of safety, satisfaction, and progress as they relate to the goals of the group, and to ensure continued consent to participate. They all allowed the group facilitators to understand which group activities were effective and positively received and which activities may need modifications to meet members’ needs. Sample questions from the mid-point focus group interviews include, “On a scale of 1 to 10, how would you rate your enjoyment of the group thus far? The safety? The effectiveness in relation to the overall goal?” and “What could we improve upon? What is missing from the group?” (See Appendix D for the mid-point focus group interview protocol.)

**Post-Individual Interviews**

The post-individual interviews occurred after all the support group meeting sessions concluded. They focused on: (a) post-survey results report and discussion, (b) GT experiences and perspectives, (c) addressing GT within the family of origin, and (d) hopes and fears for the future. Interviews lasted for about one hour and were audio-recorded and transcribed for analysis. Sample questions from the post-individual interviews include, “Researcher will provide a comparison of pre-and post-survey results. What do you make of seeing your scores together? What do you attribute the change and consistency to?” and “How have your family relationships changed since joining the group? How have they remained the same?” The post-individual interview also gave the facilitators a chance to receive feedback about the support group and the process of the study that can be implemented in future research. (See Appendix D for the post-individual interview protocol.)
Data Analysis

Qualitative Data Analysis

Qualitative data sources included the audio recordings of pre-individual interviews, support group meetings, midpoint focus group interviews, and post-individual interviews. First, each audio recording was uploaded to a transcription service, which generated full transcripts. Second, I listened to each audio recording while reading along with each corresponding transcript, reviewing the transcript for accuracy, and removing any identifying information about the members. Third, each revised transcript was uploaded to AtlasTI, a qualitative data analysis, and research software platform, and organized into folders based on the type of data source. Fourth, I performed line-by-line analyses according to the procedures of critical discourse analysis as written by Fairclough (1995): (a) reflect on the research questions; (b) examining the six dimensions of discourse (i.e., naturally-occurring language, larger units rather than isolated words and sentences, nonverbal aspects of interaction, dynamic interpersonal moves, and the functions of language use) and critical components (i.e., considering the totality of society, integrating major social sciences (i.e., economics, sociology, history, anthropology, psychology, etc.). Preliminary codes were established to extract meaning from the dialogue sources based on dimensions of discourse and critical components. Once all the preliminary codes were extracted from each of the transcripts, I grouped like codes together to formulate themes that represent members’ experiences in the support group and within their families and society related to the research questions. A codebook was developed to link themes and their definitions to member quotes, and this was shared with members for member checking.

Quantitative Data Analysis
Quantitative data sources were the pre-NGSE and post-NGSE scores. With a focus on the mean difference between two sets of observations in a repeated measures design (i.e., pre-group and post-group scores of the same or matched subjects), the appropriate method of analysis is the paired sample t-test. Members’ pre-and post-NGSE scores were analyzed to assess mean differences between the pre-and post-scores of self-efficacy for the group. This design has been utilized in similar studies involving a program or intervention and pre-post analyses (Haryono & Abdurrahman, 2020; Munir & Azam, 2017; Romero, 2012).

**Mixed Methods Data Analysis**

This study lies closer to the qualitative side on a spectrum from qualitative to quantitative research. Quantitative data were qualitized by sharing the quantitative results in each individual interview, prompting members to reflect and expand upon their scores. For example, if a member scored a value that they disagree is accurately representative of their experience, they were asked to share more about that discrepancy during their interviews. ‘QuantCrit’ draws on critical race theory to argue that quantitative data is no less socially constructed than qualitative data and that voices and insight are valuable because numbers cannot “speak for themselves” (Gillborn et al., 2018). Through these principles, I justified having members “speak” to their quantitative scores to better understand their reporting and experiences.

**Results**

Findings are aligned in response to each of the two research questions. Three themes were derived from Research Question 1: (a) deepened awareness, (b) intentional community, and (c) “abnormalizing” the normal. Three themes were derived from Research Question 2: (d) exposure to complexity, (e) turning inward, and (f) taking action. In addition, each of the six themes is discussed from the two contexts of individual and group processes and familial
and societal factors. Overall, the themes highlight member quotes describing how the group dynamic led to the outcomes. A summary of the themes is presented in Table 3. Figure 2 displays a concept map of each of the research questions, the associated themes, and how individual, group, familial, and societal processes, and factors contributed to the outcomes of the study.

**Research Question 1**

How do MBW experience and perceive familial GT throughout participation in a GT support group?

**Deepened Awareness**

Through participating in a GT support group, among other MBW, group members experienced an expansion of GT knowledge by sharing and learning from others. Through activities such as constructing family genograms, writing letters to estranged loved ones, and engaging in group dialogue that highlighted overlapping experiences, members gained awareness of how GT is transmitted within their families and upheld by homeostatic dynamics. Informational, experiential, and interpersonal learning involved members reflecting on the function of family secrets that inhibit deepened awareness, which helped to reveal ways in which they have succumbed or contributed to the transmission of GT.

**Individual and Group Processes.** As previously mentioned about therapeutic group factors, naturally, in groups, members are likely to experience the imparting of information and interpersonal learning through others’ insights and experiences about GT. The group processes led to members experiencing a deepened awareness of themselves and their familial patterns. Many of the members reported that the genogram activity was helpful for them in
identifying patterns of GT in their families, assessing how it has affected them personally, and addressing repressed emotions:

I would agree, even for me, like doing the exercise [genogram]. Or thinking about it, because I think I couldn't connect certain things because I like to block things out. And it's angering, and it's frustrating to think about stuff that I feel like I let go, and I got over. But I realized for a long time, I didn't even realize that I was molested, because I didn't call it that, and it didn't seem like that. Like it was just ‘kids being kids’, or something like that. Like, it wasn't called what it was, or it wasn’t defined as what it was. So, just realizing what I went through was difficult in the exercise.

A letter-writing activity was also facilitated in which group members were prompted to write a letter to a family member with whom they were in conflict or with whom they wanted to share something related to GT. Interpersonal learning still occurred even when a member could not personally relate to the content of another member’s letter. One group member shared her letter set in the past to her older sister, with whom she felt their relationship was subpar due to their large age difference: “So for my [letter] experience, I kind of went past tense and did my younger self to my big sister. And she's seven years older than me, so we never really had a relationship like that”. Another group member, who listened to that letter from the perspective of the older sister, reflected on her relationship with her younger sister with whom she has a large age gap, acknowledging her shortcomings:

It's interesting that you wrote it to your sister. I only have two siblings, my older brother and we kind of have a close relationship. Well, it's gotten close, we have been distant almost our entire life. But it's gotten closer. And then my younger sister, whom I was close to, but now, I mean, I've only seen her once in the past four or five years.
And when I do this exercise [writing a letter to an estranged loved one] it’s always to my mom, because that's where most of my pain comes from. But like, I’ve never really dealt with the hurt with me and my sister because I know I’m responsible for a lot of the pain that she’s going through. But I don't think she really took the opportunity or had the opportunity to see things from where I was coming from. And I would love her too because I think that would bring us closer. But yeah, you kind of struck a chord; maybe I should do that one next. I think that’s good.

Whether members could personally relate to each other’s narratives or gained awareness based on another member’s processing of their GT, the group served as a space in which members could deepen their awareness about what GT looks and feels like to them. They could begin to reflect on how it has manifested within their families as functioning transgenerational processes.

**Familial and Societal Factors.** As deepened awareness occurred for individual members within the group, this also deepened awareness of the familial and societal factors related to their families’ GT. Some reflected on how transgenerational processes have affected their parent-child relationships: “So I feel like parents are having their own thing too that they haven’t dealt with. And then somehow, it just spills onto us”. Another group member expressed a desire to understand the source of her family’s GT: “So, for me being the overthinker that I am, I’m trying to get to the bottom of why it’s so unbalanced, and there just isn’t an answer. It just started in one generation, and then it just kind of trickled down from there. So, wanting to find out where it originated is kind of what made it frustrating or maddening almost. Because it seems like it just came out of thin air.” For others, this deepened awareness led to existential inquiries:
What made me angry is that, from me, to my sister, to my mom, to my grandmother, we all had physical domestic violence, abuse. I mean, it just made me so, very angry because I'm like, ‘Oh my God’, it's just a trend of getting beat up. But I'm just like, ‘Oh, my goodness, like, why is that with us? Why are we subjected to that, like, what are we doing? Or what is causing that? Why are we attracted to this type of person?’

So that's what made me angry.

One group member chose to dedicate her letter to a dear friend, rather than a family member. Considering the role that friendships play within Black families and communities, other members were led to reflect on the importance of friendships in their lives, and how they may be impacted by GT:

With you sharing your story, I know that it's a little bit different in terms of a friend relationship. But when I think about generational trauma, I think about how there's our family, but then there's communities. Like families make up communities, and when we are healing bonds within our communities, that's helpful for us as a people overall.

And so, I wanted to thank you for sharing that perspective.

Through imparting information and interpersonal learning, group members deepened their awareness of transgenerational processes within themselves and their families and explored larger factors such as communities and existential queries.

*Intentional Community*

Group members reported that intentional community within and outside the group contributed to their perceptions and experiences of GT. Within the group, community was fostered by various factors of group cohesion (e.g., establishing and maintaining norms, fostering vulnerability and emotional safety, linking, and humor). Additionally, members
communicated that the participatory, egalitarian style of group facilitation and transparency about the research process were key components in developing their perceptions of GT. Group cohesion and participatory facilitation yielded opportunities to challenge each other to make positive changes. However, the community formed within the group led members to consider how a sense of community is maintained within their families and other societal contexts, even if the approaches to community maintenance have been maladaptive (i.e., cliques, unofficial roles, and contingent support).

**Individual and Group Processes.** The group began by collaborating on setting norms, or rules, that each group member was to uphold over the course of the group. These norms prioritized safety and growth, which laid the foundation for group members to share their vulnerabilities with one another. For example, a group member who identified as an MHP described the intense pressure she feels to perform a certain way within her family as a “chip on her shoulder”:

> I feel like a hypocrite sometimes when I’m not able to communicate in the way I think I should. And then again, I get frustrated when someone else doesn’t communicate the way I want them to, or I feel like they should.

Not only did members share vulnerable parts of themselves, but they also built on others’ vulnerabilities to connect, or link, commonalities. Phrases such as, “I’m just gonna use MEMBER, for example, since she shared previously”, “I think it’s similar to what MEMBER had said”, and “Yeah, my experience was a lot like you guys” were not uncommon. Linking across the group contributed to a true sense of cohesion; rather than the group being a sum of all its parts in which individuals simply share their unique experiences, linking allowed the group to truly join and form a cohesive community.
Humor was also a notable factor. Due to the heavy nature of GT, humor was often used as an agent for coping with and persevering through difficult topics of conversation. One group member who was grappling with the content of her genogram and reflecting on the importance of her showing up for the group stated, “And that's the only reason I'm here. Because did y'all see my genogram? It's not good.” Another group member made light of being challenged by her peers to step out of her comfort zone: “But y'all kind of came for my life a little bit in the focus group, like ‘No, you don’t need to do that,’ and all of that. It's just me standing in my own way, so this is me getting out of my own way, but still being very much scared to do that.” Following these examples, multiple other group members erupted in laughter either audibly or via affirming comments in the chat box on Zoom.

An intentional community was also set by the group facilitators’ participatory, egalitarian style approach. Aligned with the PAR paradigm of the study, facilitators embraced transparency about the research process and self-disclosing about their own GT experiences to model and ‘break the ice’ on more difficult conversations. One member responded to the process observer’s comment about facilitators’ openness:

I also like the comment about [Ashlei] and Marshaya being active members of the group. Because I think that that makes a really big difference just in how comfortable we feel talking. I know that even though last week was a really rough conversation, that was the most comfortable I felt in group.

Another group member corroborated the level of comfort allowed by the participatory style of the facilitators:
And I think you and Marshaya have done a really good job of creating a space where we do feel comfortable because you guys will often share or just be able to relate to the things that we talked about.

The last individual/group component of intentional community was challenging one another. Whenever a group member shared a vulnerability and took a risk, they were applauded:

I'm just so happy because I thought about in our focus group how you talked about not feeling comfortable sharing or like wondering if you were getting in your own way. And for you to make just such a big jump from last week, it just makes me happy. It's not only the conversation with your dad because that's major, but even like stepping outside of your comfort zone and sharing with us even though it is like a scary thing.

An aura of genuine concern for one another contributed to an intentional community in which members could develop their GT and healing knowledge and experiences.

**Familial and Societal Factors.** As an intentional community was built amongst the group members, naturally, they began to reflect on the intentional communities within their families and society. However, for many of the members, communities outside the group exhibited maladaptive functions such as cliques and ostracization, unofficial family roles, and contingent support. For some, a sense of community within the family has been maintained by ostracizing those deemed to be “lesser than”:

We have certain family members that we don’t really talk to, and so when we go on vacations and do family reunions, we don’t invite everybody. It’s like a family reunion of the people you like. And it’s a family vacation of people you like, which makes it easier, but it’s also not super inclusive.
One group member shared how unofficial roles in her family led to a homeostatic structure which she found anxiety-producing and difficult to be her authentic self in:

For me, there are certain roles that the family has chosen for everyone to play. There [are] only certain people who are allowed to make jokes; there’s only certain people who are allowed to express themselves. I remember being a super loud and obnoxious kind of kid, and it was like, ‘No, you shut up, you're not the one who should be expressing yourself right now’. And for me, it did produce a lot of anxiety because I want to be open, and I want to joke and laugh, but in the back of my mind, I’m like, ‘that’s not the role that they want me to play’. I don’t want to be uncomfortable. I’d rather just [do what I have to do] and then go about my business afterwards.

Many group members shared examples of how their families are supportive and dependable, for example: “When I wanted to go back to school, they were very supportive in that aspect of my life” and “I would say if [I] need money, I can text any of my uncles and be like, ‘Hey, I'm in a pinch’.” However, some members reported that this support and dependability were contingent or “had strings attached”. Others deduced that support was commonplace for things like money, babysitting children, and celebrating accomplishments, but not as ordinary for when someone is having a mental or emotional challenge:

We brag about each other around other company, but at the same time, whenever somebody’s really going through it, we don’t talk about it so much. So, we’re quick to share everyone’s excitement, which is great, and it’s supportive, but we’re not so quick to support each other when they’re going through a tough time and they need extra support.
Since GT has individual and interpersonal components, it is normal for group members to consider how they build and maintain community in other spaces. The intentional community of the group was upheld by factors of group cohesion, participatory-style facilitation, and supporting one another in making positive changes. On the other hand, they also considered how community had been maladaptively upheld within their families through cliques and ostracization, unofficial family roles, and contingent support.

“Abnormalizing” the Normal

Because traumatic experiences had been normalized within their families, group members expressed adamance about “abnormalizing” those traumatic experiences or changing the narrative that those experiences were necessary to endure. Within the group, they noted the universality of many of their GT experiences, including the expectation of conflict, which led them to consider familial factors such as being dismissive of constructive dialogue about trauma. Despite their universal experiences, they declared that they should not have to be.

Individual and Group Processes. One part of acknowledging how normalized GT is within families was a conversation about “big T traumas” versus “little T traumas”, or more intense and acute experiences (e.g., physical abuse) compared to those that are non-life-threatening but still impactful (e.g., emotional abuse). Across the spectrum of both these types of traumas, members reported an aura of normalcy and acceptance that became inherently harmful. One member, in particular, expressed frustration about family members’ lack of awareness of the normalizing of traumas:

I think it’s so like fucked up how in a lot of our families, they’ll try to make big T traumas, little traumas because they happen so often. And so, this lack of recognition that abuse is a big T trauma, they laugh it off. It just drives me fucking crazy because
it’s just so dismissive. And I get that [it’s] a survival thing, I get that it’s a conditioning thing, but [it] makes me even more frustrated because [they] don’t even see how much [they’re] hurting.

Another group member expressed how the lack of acknowledging little T traumas contributes to the transmission of GT within her family:

That little T trauma feels very big. It’s so interesting how we will acknowledge the big T traumas, but we’ll never acknowledged the little T traumas, and those are the things that continue to be passed on. Those are the things that continue to permeate in our families, and we don’t ever acknowledge it.

Lastly, one group member voiced how easy it is for her to talk about a conventionally taboo topic and one in which she was victimized (i.e., sexual assault), but more difficult to engage in a discussion about GT in which she must admit her shortcomings:

Surprisingly enough, it’s pretty easy for me to talk about being sexually assaulted, but I think things that just evoke different feelings are very hard for me to discuss. It’s hard to admit that I did something really hurtful to somebody that I really care about; to have to be vulnerable enough to be like, ‘I fucked up, and I fucked up in a big way’. It is hard.

The normalizing of harmful traumas contributed to the desensitization of those experiences, and through the group, members expressed a desire to decenter those experiences as normal to embrace healthier ways of coping and functioning.

**Familial and Societal Factors.** Similar to the above member’s self-revelation, this group member realized how her family’s avoidance of using appropriate terms to describe child sexual abuse equates to their ignoring it and downplaying its effects:
My mom, I had to correct her because she would say, ‘he plays with’, or ‘they played with them’. And that's not the correct term. They molested. Because if you don't use the right terminology, [you’re] basically justify[ing] it, or you minimize the actual damage of what that adult has done to that child. And I realized that’s language that we have in our family.

Another group member expanded upon individual and group processes to share how her family’s dismissiveness shows up in the form of mental health stigma and denial that any sort of help of correction is needed: “I told my mom that I was doing this [group], and she was like, ‘What do you mean? What GTs do you have? What issues do you have?’”. Despite that member’s multiple counts of traumatic experiences, including those related to GT, the insistence that their family is “normal” contributes to the cycle of a lack of desire to change harmful patterns. Another group member shared of an interaction she had with her dad in which she attempted to initiate a constructive conversation about a rupture between them:

My dad said, ‘I guess I’ve just been a horrible father your whole life? What happened? I thought we had a good relationship. Can’t you just get over things?’ And I was like, ‘nope’, so I didn’t talk to him for nine months.

Her father’s denial of her little T trauma and dismissiveness in even engaging in dialogue about it was ultimately challenging enough for her to distance herself from him.

When traumas are deemed normal within families and communities, they are not viewed as issues that deserve attention and care.

**Research Question 2**

What is the relationship between participation in a GT support group and self-efficacy in addressing GT within the family of origin among MBW?
**NGSE Analyses**

Initial steps included checking the general assumptions for paired-samples \( t \)-tests, according to Pallant (2005):

1. **Level of measurement**: It is assumed that the dependent variable is measured using a continuous scale rather than discrete categories. This assumption is met; the NGSE scale is continuous one.

2. **Random sampling**: It is assumed that scores are obtained using a random sample from the population. This assumption is not met, as the sample was obtained utilizing a purposive, convenience sampling technique. However, this assumption is rarely met; most studies have some type of sampling bias.

3. **Independence of observations**: It is assumed that each observation or measurement must not be influenced by any other observation or measurement. Because this study operated within a group setting, the assumption is violated and not met. The behavior and narratives of each group member inevitably influenced all other group members. Because this assumption is not met, it is recommended to set a more stringent alpha value (e.g., \( p < .01 \)).

4. **Normal distribution**: It is assumed that the difference between the two scores obtained for each group member are normally distributed. While this assumption was not met, a lot of social science research yields distributions that are not normal. However, because the sample size was not large enough (e.g., 30+), the violation of this assumption is considered further. Figure 1 displays a histogram of the sample’s distribution.
The pre-post administration of the NGSE revealed members’ decreases in self-efficacy \((n = 5)\), no changes in self-efficacy \((n = 4)\) and increases in self-efficacy \((n = 3)\). The results reveal that members scored slightly higher on the pre-group measure \((M = 4.47, SD = .56)\) than the post-group measure \((M = 4.29, SD = .58)\). The mean difference between the pre-group and post-group measures was \(-.18\), which was not statistically significant, \(t(11) = 1.28, p = .229\). Overall, the group means were high, since the NGSE is on a five-point scale. Although the mean difference was not significant, an effect size (Eta squared statistic) was calculated in order to assist with the interpretation of the results. The Eta squared calculation resulted in an effect size of \(.13\), which is considered to be large. Non-significant results with a large effect size may indicate that the sample size was not large enough for the mean differences to be significant.

**Exposure to Complexity**

Through participating in a GT support group, members reported that exposure to the complexity of GT yielded changes in their self-efficacy. Complexity included various presentations of GT, the discovery of how others cope with and manage it, and the realization that there is more than one pathway to healing. This led members to deconstruct and reconstruct their personal definitions of GT and healing, as well as shift from dichotomous thinking to more of a more fluid-like schema.

**Individual and Group Processes.** The majority of the group members showed some type of change in their self-efficacy, whether it was an increase or a decrease \((n = 8)\), and each of them reflected on how the group revealed to them just how complex GT and healing can be. One of the group members who exhibited a decrease in her NGSE score reflected on what contributed to that decrease: “Nobody is perfect at tackling GT. I just feel like when I answered last time [pre-survey], I was overly confident. It’s harder than what I expected,
doing some of the activities and writing the letter.” For her, exposure to how complex GT and healing are, coupled with engaging in some of the group activities contributed to her taking on what she felt was a more realistic approach to addressing GT at the end of the group. On the other hand, another group member who demonstrated an increase in self-efficacy attributed this change to the sense of community she got from the group:

I think my increase speaks to how connecting the support group was. I’m not; we’re not the only ones traversing this path [of GT]. The group gave a sense of community, and even though everyone’s vulnerability was shown, that helped for me to see how other people are dealing with it, and it gave me some ideas.

Of the four group members who had no change in their scores across the pre-post administrations, three of them identified as MHPs. Each of them cited their backgrounds as MHPs when discussing the consistency in their scores, for example: “I’ve always had a good level of self-awareness with this stuff. I’ve always been having these conversations, but now they’re more in-depth.” Thus, although they were impacted by the exposure to complexity within the group, it did not have a significant effect on their NGSE scores.

**Familial and Societal Factors.** As exposure to the complexity of GT and healing within the group led to changes in self-efficacy, group members’ definitions of GT and healing expanded to reflect a shift from dichotomous to more fluid-like schemas of GT and healing. One group member shared a revelation about her expectations of what generational healing entailed:

And I think what [MEMBER] said about how [one] conversation won’t necessarily fix everything, but at least being heard is helpful. I think that helped me just kind of get a better understanding of, like, what the goal is in the conversation and overall. Like,
this might not solve everything, but at least having the conversation is a step towards the right direction.

Furthermore, one of the group activities prompted the members to identify strengths and areas for growth within their families. Through this activity, many of the group members expressed their realizations of how the strengths and areas for growth tended to overlap (i.e., within a single-family), as well as overlap across different families in the group. For example: “I found this exercise a little bit challenging because I noticed that a lot of the strengths and areas for improvement were related to one another” and “I thought of two strengths and two weaknesses. But the more I think about it, the more it feels like all of those four things were related”. Lastly, this complex, non-dichotomous thinking caused some members to develop more empathy for some of their family members with whom they have tumultuous relationships:

I was trying to put myself in [my father’s] shoes in order to make sense of that [complexity]. And I feel like I was kind of able to get somewhere, and it did help. I was able to actually have a conversation with him, and things are a little bit sketchy still, but we are on speaking terms.

Although some group members entered the group with a confident mindset about addressing GT, participating in the group exposed them to a complexity that they had not seen before, which encouraged them to expand their schemas of GT and healing beyond a dichotomy to make room for more constructive approaches.

**Turning Inward**

Following changes in self-efficacy and expanded definitions of GT and healing, group members shifted from taking on a “savior complex” (i.e., wanting to “save” their families
from GT) to tapping into personal accountability and receiving feedback about their individualized approaches to addressing GT. On a larger scale, this manifested as members’ tendency to distance themselves for peace and clarity and shift the focus of their efforts from older generations (i.e., parents and grandparents) to themselves and future generations (i.e., children, nieces, and nephews).

**Individual and Group Processes.** Sometimes turning inward for members was followed by frustrations regarding others’ unwillingness to engage with them in a healthy way. One member shared her experience of turning inward while practicing GT-specific communication skills learned in group:

One thing that has helped even though I do struggle with it, is reminding myself that I can only control what I do and me talking in ‘I’ statements helps me in the long run, because I know that it’s improving the conversation. But being okay with however someone responds, that doesn’t reflect me in any way. I don’t want to say, ‘I did what I was supposed to do’. But that’s kind of the mindset that I have. I achieved the goal of using this soft conversation skill when previously I struggled with it. I’m not saying all the time it's successful, but we're working on it.

On the other hand, a different group member who was not as confident in her skills expressed her turning inward as a prerequisite for being able to engage with the family in a healthy way: “My emotional IQ ain’t up there yet. Because I'm trying to unlearn and relearn at the same time. I've been working on it, and it's definitely a skill you got to do every day.”

One of the group activities encouraged members to share their personal definitions of GT and healing. With these definitions, the facilitators pieced together virtual “quilts”, representing the uniqueness of everyone’s experiences and the connectedness and community
between a group of MBW intentionally working on improving themselves and, ultimately, their families. These quilts also represented a connection to the study’s epistemological framework, BFE, in which quilts have used a metaphor to describe the experiences of Black women. (See Appendix F for images of the group’s GT and healing quilts.) Despite the group having an individualized focus, zooming in on members and their unique experiences, some of the squares in the quilts revealed just how personal GT and healing journeys are. One of the personal definitions of generational healing was: “Healing that takes place in an individual to break generational patterns. This healing can help future generations and also foster healing and growth in older generations”. Turning inward for some members allowed them to discover that healing individually is an important component of improving the transgenerational process of Black families.

**Familial and Societal Factors.** One of the familial and societal factors of turning inward translated to distancing oneself in order to gain peace and clarity regarding GT. Group members reported how difficult it is to sift through thoughts and emotions all while trying to handle a relationship in a manner more conducive to healing, which requires significant changes. One group member shared how her cross-country move away from her family for the purpose of attending school gave her a sense of peace and gratitude that she desires to continue even after she graduates from school:

> It’s sad to say for me, I’m kind of grateful that I live far from my family. Because when these holidays come up, I just don’t want to be around them. And I can justify being a poor grad student, and I’ve been using that for the last [few years].

Another group member expressed a desire for more emotional distance while shifting her focus to herself and the next generation: “Man, there's a lot of shit going on in my family,
and I need to work on myself so that I don’t duplicate that or imitate that with my nieces and nephews, or when I have my own family”. In these cases, complexity led to a redefining of GT and healing, which led to turning inward and focusing on the self and future generations.

**Taking Action**

Because this group study was designed around a PAR paradigm, ‘action’ components were embedded into the curriculum of the group. Even though all activities and prompts were optional, all group members were fully engaged even when it was emotionally difficult, with the goal of being able to apply insights and skills learned in the group to the outside world. This involved them mending troubled relationships and making short- and long-term commitments to disrupting maladaptive transgenerational processes.

**Individual and Group Processes.** In the post-individual interviews, members were prompted to share the group activity that was most useful for them in taking action. One member, an MHP, shared that learning about communication skills and utilizing the group as a space to practice them was helpful: “As a clinician, it’s hard to practice what I preach to my clients. But this allowed me to be a ‘client’, practice those skills, and get feedback from others.” Another group member reported that the genogram activity was most useful for her because it allowed her to learn about patterns unbeknownst to her and provided an artifact with which to facilitate conversations with family members:

The genogram was really cool. It was impactful for me because I’ve never seen anything laid out in front of me like that. I even went to ask questions about my family; there were so many new things I learned. It was helpful to know patterns of depression, substance abuse, et cetera.
Conversely, at some points, the support group became so heavy and challenging that members expressed difficulties in showing up. For example, one group member disclosed the reason she was late for one meeting:

The reason I was 10 minutes late is because I had to collect myself. I didn't want to be here because I knew it was going to be heavy. I'm sure I'm not the only person in the group who has kind of had a hard time pushing through… Yeah, even [MEMBERS] said that in previous weeks.

Other group members also resonated with this sentiment and shared why they decided to persevere through the end of the group:

Honestly, the reason I was late is because I'm not feeling it right now. And now, the reason I stayed is because I realized that the reason I wasn’t feeling it is because I was still in the process of trying to avoid things welling up.

Despite the emotional challenges that arose for group members, they were still committed to showing up and “doing the work”, maximizing the group activities to meet the goals of what they desired from the experience.

**Familial and Societal Factors.** Some group members’ taking action involved them mending relationships within their families and communities. The letter-writing activity did not involve members sharing the letters with their recipients; it was designed to be introspective and an opportunity for getting feedback from the group. However, one member maximized on a timely opportunity that presented itself:

I kind of took it two steps ahead because I did the [letter-writing] thing and then my dad was unexpectedly in town. I ended up being able to have that conversation, although it was very premature. I did kind of struggle with said discussion. So, I really
enjoyed the activity because at least I didn't feel like I was stammering on my words. I knew what I wanted to stay. Even though I wasn't emotionally ready to actually have that conversation, I was kind of forced into it.

Because of the skills imparted in the group and the letter-writing activity that warmed her up to expressing herself to her father, this member was able to take advantage of her father being in town to have an honest conversation with him, which she reported was a “step in the right direction” for them. Another group member had a similar experience with the timeliness of the letter-writing activity in having a conversation with a friend:

I definitely felt like I was kind of like nervous as I was having the conversation and I was very quiet and reserved. But I think starting by doing the [letter-writing] activity beforehand kind of prepped me because I knew what I wanted to say instead of just trying to think on my feet. I think that helps in more ways than I thought it would.

Through the group activities, members were able to “practice” expressing themselves and having constructive conversations about GT with loved ones.

Not only were group members taking action themselves, but on a larger scale, they also encouraged the facilitators to ‘take action’ by continuing to foster these types of spaces in the future. One group member stated, “Ashlei and Marshaya, y’all need to trademark this thing [the GT support group] and take this around like the country. I’m so serious.” Their insistence upon the usefulness of the group and this type of space for MBW inspired her to express support for expanding the services provided by the research team to reach additional, relevant communities.

Revisiting Figure 2, the visual depicts Research Question 1 producing the first three themes (i.e., deepened awareness, intentional community, and “abnormalizing” the normal)
and Research Question 2 producing the last three themes (i.e., exposure to complexity, turning inward, and taking action). Research Question 1 is at the top of the map, with its themes placed in a linear fashion downwards towards the center. This represents how members’ perceptions and experiences were deepened and “broken down” to deconstruct their preconceived notions about trauma and GT. On the flip side, Research Question 2 is at the bottom of the map, with its themes placed linearly in an upward motion towards the center. This set of themes is also encapsulated to note how changes in self-efficacy were connected to each of these themes. It is no coincidence that the two sets of themes mirror each other within the figure; this is also indicative of the manifestation of the themes within the group. For example, deepened awareness resulted in exposure to complexity (which impacted their self-efficacy), intentional community led them to turn inward, and so on and so forth. Overall, each of these themes was influenced by individual and group processes as well as familial and societal factors, of which the descriptions and data to support the themes are consistent.

**Discussion**

The purpose of this study was to understand better how MBW perceive and experience GT within a participatory, action-based support group and to examine their self-efficacy in addressing GT in their families throughout the process. Findings revealed members’ deepened awareness, intentional community, and “abnormalizing” the normal, in addition to changes in self-efficacy, turning inward, and taking action, all through the lenses of individual, group, familial, and societal contexts. Each of these themes are discussed as they relate to the following topics: GT, group therapeutic factors in action, revisiting self-efficacy (and the Dunning-Kruger effect), knowledge versus wisdom per the study’s BFE foundations, and advocating for mixed methods designs in research.
Connections to GT Literature

Overall, this study corroborates previous findings and assertions that Black Americans experience ‘residual effects of slavery’ that have permeated Black Americans’ individual psyches, family systems and relationships (Wilkins et al., 2013). Examples presented by Wilkins et al. (2013) were shared by group members, such as: stifling natural responses to oppression or mistreatment in order to survive or maintain balance, parents having difficulty with praising their children or acknowledging their accomplishments, and a reliance on female family members to address and resolve the emotional and relational hardships of interpersonal issues.

This study’s results also built on the results of the previous study. The previous study’s theme of ‘collectivistic yet disconnected’ detailed participants’ assertion that they feel physically close to their family members (i.e., spending time together), but that they lack emotional closeness and healthy repairs to ruptures. Group members’ experiences in the present study revealed the theme of ‘intentional community’ which highlighted how their familial communities were intentionally maintained to be connected in some ways and disconnected in others, such as being financially and physically supportive, but not as emotionally supportive of endeavors that were not typical for their family. The previous study’s theme of ‘functioning in dysfunction’ was also supported by the present study’s theme of group members wanting to ‘abnormalize the normal’; that is, acknowledging that the dysfunction is too common for their liking, and that they would like to change it. Lastly, the previous study’s theme of ‘motivation to change’ connects to the present study’s themes of ‘turning inward’ and ‘taking action’. Although Wilkins et al. (2013) described the impacted Black Americans’ individual psyches as powerless and passive due to continued oppression,
both previous and present studies demonstrate a strong desire to change, coupled with actions demonstrating that desire to change. Despite the homeostasis present, participants and group members still see ‘the bigger picture’ and aim to improve familial conditions for present and future generations.

**Group Therapeutic Factors in Action**

Deepened awareness and intentional community are reflective of extant literature on group processes and their potential for empowerment through the shared space and goals of the group. These two themes are related to some of the group therapeutic factors previously described: imparting information, corrective recapitulation of the family group, socializing techniques, interpersonal learning, and group cohesiveness. As explained by Yalom and Leszcz (2020), the group turned out to be one of “partnership and collaboration” (p. 9) in which group members immersed in a reciprocal process of learning from each other and teaching others by sharing their experiences and thoughts with the group. By being help givers and receivers simultaneously, group cohesion factors of the intentional community sub-theme (e.g., naturally occurring language, encouraging each other to make positive changes, and humor) contributed to their abilities of taking action benefitting from the group in unique ways. Additionally, one of the sub-themes of familial and societal factors, existential queries, revealed some members’ thought processes surrounding patterns that were revealed to them in the genogram activity. For example, when one member discovered a pattern of interpersonal violence with the women in her family, she asked questions such as “why us?” in an effort to cope with and make sense of the dynamics within her family that unfortunately affected her too.
The theme of “abnormalizing the normal” is connected to the group therapeutic factor of universality, as described by Yalom and Leszcz (2020). Universality is the common denominators between members of the group, despite their complex, human differences. As can be seen from the table of member demographics (see Table 1), group members shared identities such as race, gender, and even sexual orientation. However, their unique experiences of ethnicity, religious/spiritual beliefs, education and occupation backgrounds, relationship and parenting statuses, and their history of traumatic experiences observed from the THQ and individual interviews allowed for a communal experience in which they could connect with one another on the shared phenomenon of GT and teach to and learn from each other given their unique experiences. Group members expressed similarities in traumatic experiences and maladaptive family dynamics such as the normalizing of harmful communication and minimizing of sexual assault and child molestation. The universality of their experiences led them to a desire to “abnormalize” these experiences or decenter the expectation of these experiences to replace them with healthier expectations.

Relatedly, the themes of turning inward and taking action are connected to the group therapeutic factor of corrective recapitulation of the primary family group. Consistent with extant literature, group members tended to show up in group in a similar manner to how they show up with their families. This experience served as a mirror for them to examine their interactions with family members. Through the support group, group members turned inward to examine their own roles within their families, including how they themselves have contributed to the transmission of GT thus far. This process also led members to reflect on how taking on the “Strong Black woman” trope and taking responsibility for the plight and healing of their families led them to initially conceptualize healing from that same
perspective: taking on the responsibilities and healing of others. However, turning inward allowed for them to shift their perspectives to prioritize themselves and focus on their natural responsibilities to the subsequent generation rather than trying to “fix” everyone in their families. This shift in thinking ultimately results in a shift of how they show up emotionally and behaviorally with their family members.

Lastly, McCarthy et al. (2021) demonstrated that group work is a primary method for diverse populations to achieve goals. Additionally, research which showed that Black Americans express both individualistic and collectivistic family dynamics revealed themselves all six of the current themes. Deepened awareness showed that some had to connect with family members in order to learn more about their transgenerational process. Intentional community solidified the importance of healing amongst one another instead of isolation, which was also demonstrated in the previous study (Petion et al., 2022).

“Abnormalizing” the normal revealed to some group members that they may have to disrupt their families’ homeostatic patterns in order to achieve the healthier dynamic that their desire. This sort of ‘going against the group’ would be more aligned with individualistic tendencies, but the overarching goal represents a desire to improve the collective of the group on a larger scale. Exposure to complexity led them to reconsider definitions of GT and healing, in which they turned inward to focus on their own healing before attempting to “fix” everyone else. Lastly, taking action represented both individualistic and collectivistic behaviors: some members’ action manifested as them writing letters to a loved one to sort out their feelings, while others chose to deliver those letters to their loved ones in an effort to mend a turbulent relationship. Overall, both individualistic and collectivistic traits can be observed from the
group processes and resulting themes, which demonstrates an extension of the literature on Black Americans bi-cultural nature.

**Revisiting Self-Efficacy**

In the present study, it was hypothesized that assessing members’ self-efficacy specifically with regard to addressing GT might reveal some significant changes, but this was not true for group members. Literature on self-efficacy has considered general self-efficacy to be a rather stable trait regardless of external factors such as programs and interventions (Chen et al., 2004). Furthermore, members who demonstrated a decrease in self-efficacy verbally expanded upon their scores to share why they felt they scored lower on the post-group NGSE. We are also led to consider the concept of perceived, self-reported self-efficacy compared to actual self-efficacy as well as their actions. For instance, how they perceive their ability to address GT compared to their actual ability to address GT and the actual actions they will take. We acknowledge that these concepts may be three different sets of skills or actions. Overall, because there was no observation of a significant change in the group mean, it is concluded that this study supports extant literature on self-efficacy. Consequently, centering Black women as agents of their own knowledge leads us to consider the BFE concept of “knowledge versus wisdom” as it relates to balancing formal knowledge of GT and the ability to navigate structures of GT socioemotionally. The Dunning-Kruger effect, a re-exploration of BFE’s knowledge versus wisdom, are discussed, followed by a discussion of the importance of mixed methods research, limitations, and various implications.

**The Human “Blindspot”: The Dunning-Kruger Effect**

The Dunning-Kruger effect is a cognitive bias in which a person with low ability is more likely to overestimate their true ability in a particular social or intellectual domain.
As they learn more about the domain, they are more likely to rate themselves lower than before, at more realistic levels. In the case of this group, the domain was self-efficacy with regard to addressing GT, and the members demonstrated rather high self-efficacy across the course of the group, with a statistically insignificant decrease at the post-group measure. Their qualitative narratives also corroborated the findings in that they generally felt confident in their abilities to have difficult conversations about GT within their families and to help disrupt the cycle. Could it be that group members are still in what Dunning-Kruger literature might call a “blind spot”? On the other hand, many of the group members shared about their family members’ ignorance of the processes of GT, including their dismissive tendency to avoid constructive conversations about healing GT, so much so that it contributed to one of the themes of the study (i.e., “abnormalizing” the normal). Many of them are living in denial about how their actions, and the relationships they have with others, are contributing to cycles of GT within their families.

It would be remiss of me not to consider the role of culture in these conversations about self-efficacy and overestimation biases. Concepts such as self-esteem and self-efficacy have long been viewed as Western notions that do not align with that of Eastern and other collectivistic cultures (Rahmani & Lee-McFadden, 2017). Black Americans are often viewed as a collectivistic culture due to their African roots, but still possess many individualistic customs unique to Americans as a whole that might contribute to inter-cultural confusion about where Black Americans may lie on the individualistic-collectivistic spectrum. All things considered; it is important for us to distinguish between Dunning-Kruger effect literature that portrays incompetence in a negative light. This type of portrayal is not aligned with the framework of this study. Rather, we aim to facilitate literary discussions about the cultural
implications of different ways of establishing and imparting ways of knowing. In essence, high self-efficacy does not indicate that they are necessarily incompetent; I suppose that it means they possess a different way of knowing that is more aligned with their cultural norms.

In addition, it is important to consider the above knowledge in conjunction with what is known about counselor cultural competency. The Multicultural and Social Justice Counseling Competencies (MSJCCs) (Ratts et al., 2016) discussed counselor self-awareness, client worldview, counseling relationship, and counseling and advocacy interventions through the intersecting lenses of counselors’ aspirational competencies of attitudes and beliefs, knowledge, skills, and action. Each of these concepts are considered lifelong quests in response to an ever-changing world rather than targets to be met at a single point in time. As such, various literary arguments have been made about how counselors’ self-awareness impact how they might show up with clients (e.g., their perceived and actual self-efficacy). For example, Singh et al. (2020) purported that the MSJCCs and the attitude of cultural humility are elements foundational to the counseling relationship and process, and that this reflects an overall call to action necessary for effective counseling skills. In considering how counselors’ cultural competency and humility interact with their self-efficacy, we are led to consider how this translates to the current study with group members’ self-efficacy in addressing GT within their families. We parallel a ‘consistent, constructive approach’ to addressing GT with that of cultural humility: they are both attitudes to be invested in on a long-term basis which involve a stance of lifelong learning and effort in order to achieve a positive, constructive outcome.

**Knowledge versus Wisdom: BFE Foundations**
This study has a strong foundation in BFE with tenets of lived experience as a criterion of meaning, the use of dialogue in assessing knowledge claims, the ethic of caring, the ethic of personal accountability, and Black women as agents of knowledge (Hill Collins, 2009). As can be reasoned through the methodology and procedures of the study, Black women’s experiences and what they make of them are paramount in piecing together the meaning of the results. As such, we consider the two types of knowing, per BFE: knowledge and wisdom. As previously stated, knowledge is regarded as more “book smarts”, while wisdom is more “street smarts”. To connect this metaphor to GT, knowledge could be seen as being familiar with GT definitions and literature, while wisdom about GT involves actually knowing how to navigate, and having experience with navigating, the socioemotional processes that make up GT in our families. This distinction can be applied to their changes in self-efficacy as a result of exposure to complexity within the group. They may have originally rated themselves higher in self-efficacy of addressing GT based on “knowledge” or awareness of GT definitions, but after engaging in action-centered dialogue, they may have reconsidered their perceived abilities to be more accurate of their actual abilities (i.e., “wisdom”). It is also notable that many of the group members justified a decrease in their pre-post NGSE scores by expressing a confidence in their ability to navigate oppressive systems. That is, they originally felt confident in being able to address GT in their families due to their personal successes in having navigated oppressive systems in society. I suppose that if we replicated the present study and conducted pre-post assessments about both knowledge and wisdom of how to navigate GT, that we might observe more significant difference due to it being more aligned with our (i.e., Black women’s) ways of knowing. While knowledge and wisdom are not necessarily mutually exclusive, we continue to draw parallels with the themes of the present study, the most relevant one being the non-
dichotomy of experiences that stemmed from members’ exposure to the complexity of GT. Their realization that there is more than one way to heal from GT and that it involves multiple different individual and collective components represents a fusion of the knowledge and wisdom as described by Black Feminist Thought (Hill Collins, 2009).

Furthermore, I consider how BFE seeks to challenge the idea that formal education and Western epistemologies are the only routes to pursue knowledge (Hill Collins, 2009). Through the GT support group, members “turned inward” to better understand what GT looked like and felt like to them as individuals. This was made possible through group therapeutic factors, which also demonstrated overlaps with BFE (e.g., caring for others, dialogue in assessing knowledge claims). Then, those reflections were pieced together with other group members to develop a visual of these individualities with common “threads”. Appendix F displays the BFE-style “quilts” that the group constructed in the virtual space, and those definitions were based on a deepened understanding of their own lived experiences and wisdom with which they have navigated GT and healing. Now, this study has the honor of serving as a vehicle that connects the wisdom of 12 MBW with GT to existing bodies of inquiry, which was the true goal of the study and its PAR framework: collaborating with individuals in communities to gain awareness of problems we/they face and to encourage them/ourselves to take action towards those problems, all while acknowledging and working to dismantle larger power structures.

**MMR Advocacy**

Reflecting on the combination of self-efficacy and BFE literature, I continue to advocate for the use of mixed methods designs as valuable, respected, and primary ways of exploring phenomena and constructing knowledge. Had we solely conducted a quantitative study examining pre-post NGSE scores, our conclusions would have been subpar, failing to
illuminate the justification and reasoning behind group members’ varied scores on self-efficacy and focusing on the non-significance of the data. It could have been assumed that they were generally highly self-efficacious, that participating in a group had little effect on their perception of GT, and that they are not in need of a space such as the support group offered by this study. Rather, what cannot be observed from the mean differences alone are the qualitative themes of the study which revealed the importance of spaces such as this one. On the other hand, had we solely collected group dialogue data and not interviewed each member individually, we may have missed out on more authentic reports and intimate opportunities to connect with each group member to learn about their unique experiences within and beyond group. We also would have missed out on a streamlined, standard way to measure the construct of self-efficacy across group members. The mixed-methods, iterative sequential design allowed for researchers to gather multiple different types of data in succession, where one phase influenced the next to be reflective of their needs and experiences. This process clarified the nuance of their self-efficacy including their experiences within the group and in their families. As such, this study serves as an example of mixed-methods research that prioritizes the voices of its participants to draw conclusions that were reflective of their experiences.

Limitations

The results of this study must be considered within the following limitations: member demographics and attrition, study timeline, quantitative measures, and data analyses. First, the members were a highly educated group, with all of them having earned at least an undergraduate degree. Being that participation was limited to those with stable internet connections and ample time and emotional energy, this may have eliminated MBW in different
socioeconomic statuses or employment or parenting situations who were not able to afford the
resources or time to commit to participating. Additionally, each of the group members self-
selected to participate, and more than half of the members identified as being a MHP, MHP-in-
training, or holding some sort of degree in a MHP (n = 7). Their educational backgrounds and
willingness to participate may indicate some level of readiness or baseline self-efficacy that is
not representative of all MBW with GT. However, many of the members who were MHPs
acknowledged that their identities as MHPs contributed to the complexity and difficulty of
addressing GT within their families due to mental health stigma, ostracization due to their career
choices, and family members’ increased pressure on them to fit a preconceived role of what an
MHP should be. Additionally, the education levels and MHP backgrounds of some of the group
members could demonstrate a crystallization of their commitment to the process via participation
and action; PAR principles. Their understanding of the research process, empathy for the
research team in attempting to conduct a very complex study, and their readiness to make
changes within their lives could all be viewed as positive contributions to the study. Attrition was
also a concern, as three group members dropped out of the study within the first two weeks.
However, I recruited at the top end of the range requested by the committee (i.e., 12-15). Even
after attrition, the range request was still met, and 12 members led to saturation of the data.

One of the traditions of PAR is that researchers spend significant amounts of time in the
communities they are collaborating with. Given the PAR paradigm of the study and the
condensed timeline, the group could have benefitted from having a longer curriculum. This could
have given the group additional time to connect, build rapport, and learn and practice skills more
extensively. However, due to the academic time constraints of the primary researcher, this
limitation was navigated by being transparent with the members throughout the timeline and
providing guidelines for following up on the foundation built within the group. Although this study only spanned ten weeks, I argue that this research built upon knowledge constructed in the previous study, in which I studied GT in Black women college students over the course of about two years. Additionally, because members were not part of a pre-established community (i.e., they were all strangers at the start of the study), we could also argue that the community of the group was being built as the research team was studying it and that the formulation of that community was part of the study. The research team’s shared identities of being MBW could also indicate a decreased amount of time needed in community, given that traditional PAR studies are designed around researchers holding differing identities than the participants.

This study’s analyses relied solely on the primary researcher rather than a traditional coding team. While this is certainly a limitation, we took several different measures to ensure crystallization in other areas. Instead of crystallization occurring through a coding team, it was demonstrated through multiple different sources of data, all corroborated by the members through weekly process observations, focus group interviews, and member checking of the final codebook. Through these actions, the research team is confident that the results presented are reflective of the voices of the members.

It is also important for us to report on the limitations of the measures used in this study. The THQ has a low stability coefficient, signaling that members’ responses to this measure may vary across reporting. THQ data was only collected once before the start of the support group. Its primary use was to help screen members for appropriateness and fit for the group and for the co-facilitators to build a curriculum responsive to the unique needs of the members. This study was less concerned about the specific, individual traumatic history of each group member and more concerned with their GT experiences and the narratives they brought to the group. The NGSE,
however, was collected across two-time points and analyzed for mean differences. Twelve members are a small sample size that cannot be generalizable to all MBW. However, the generalizability was not an aim of this study, nor was it reflective of the design and framework of the study. Lastly, this study examined members’ self-efficacy with regard to addressing GT in their families. Self-efficacy is often critiqued as portraying a gap between a belief in one’s ability and their tendency to act on those beliefs to make the changes they believe they can make. This gap could be an implication for future study. With both measures, it is important to address response and desirability biases or the possibility that members responded in a way they felt would make them more favorable to others. Due to the PAR paradigm of the study and the transparency with members throughout the research process, members were made aware of the research questions, the hypotheses of the study (i.e., increased, stabilized, or decreased self-efficacy), and they were assured that there were no desired outcomes on the part of the research team. Members scored in all three categories of self-efficacy, and their scores were authenticated by other data sources such as their individual and focus group interviews, where they expanded upon and gave voice to their scores.

All in all, many of these limitations could be considered delimitations, or intentional choices and boundaries set by myself and the research team in order to strengthen the study in various ways. By a reciprocal nature, while strengthening the study in one area, another area may have been weakened.

**Implications and Future Directions**

This study demonstrates promising implications across individuals and communities, counseling and practice, counselor education, and future research. In true PAR fashion, this study is primarily concerned with implications for the individuals and communities that it
represents (i.e., MBW). PAR is also concerned with the distribution of findings across other relevant communities impacted by GT. Following the dissertation and potentially exploring avenues for academic publication, I aim to make this study accessible by distributing its results in the same place I recruited 11 of the 12 group members: social media. Contributing to the growing body of resources on GT and generational healing, such as fact sheets, videos, and infographics on social media, I aim to share the information targeting communities that struggle with GT. Similar to the experiences of many group members, sometimes individuals lack the language to describe what they are experiencing, and they lack the exposure and knowledge to identify GT, let alone address it. By distributing more accessible resources, we can enlighten communities through individuals who are more aware of familial and societal factors that impact their wellbeing and influence on following generations.

In the counseling arena, this study sheds light on the importance of MHPs’ ability to recognize and treat individuals, couples, and families presenting with issues surrounding GT. Group members’ narratives can help counselors empathize with these clients, shifting foci from more individualized treatment to collective, culture-centered interventions. Additionally, the curriculum constructed as part of this group study could serve as a springboard for developing a manualized group curriculum for treating GT and facilitating generational healing. We learned through the previous study as well as this one that GT can feel incredibly isolating to individuals and that when surrounded by others with shared identities and experiences, one can benefit from therapeutic group factors such as universality, corrective recapitulation, interpersonal learning, installation of hope, among others. Since we had to modify an existing, individualized trauma measure to capture data on GT, constructing a standard measure for assessing familial GT could be helpful for clinical and even research
settings. Lastly, this study could help inform best practices within the counseling profession for evidence-based approaches to assessing and treating GT.

The counselor education profession must also be considered in future implications. Currently, trauma counseling is not a required course in the masters- or doctoral-level training curriculum. Even when programs offer trauma counseling courses as elective options, they likely do not sufficiently cover GT. Aside from training future counselors to recognize and effectively treat GT, this PAR study has implications for what we teach them about how counseling fits into communities and how we can work with them to achieve common goals. Counselor education programs that have advocacy and community-related projects may use this study as an example of how to collaborate with a community to learn from them, develop and implement interventions, and make positive changes in those communities that are reflective of the specific needs of the community.

Continuing to build on the previous study, this dissertation represents a springboard for a career-long research agenda in GT and healing. With regard to methodology, I would like to examine how PAR studies can be used to help communities to help themselves on topics that are typically relegated to professionals (e.g., mental health and relational issues). Implications also exist for this study to be an example of mixed methods research that centers on participants’ voices through qualitative inquiry and the critical examination of quantitative research with participant voices. Lastly, both the previous and current studies revealed a substantial interest and value in using genograms for deepened awareness, conversation-starting, and journeys to treatment and healing. A follow-up study examining the genogram’s use in facilitating awareness of GT and other mental health symptomology could yield interesting and valuable results.
Conclusions

This study aimed to better understand how MBW perceive and experience GT within a participatory, action-based support group and to examine their self-efficacy in addressing GT in their families throughout the process. Although group means revealed a slight decrease in the group’s overall self-efficacy, qualitative themes revealed processes through which changes in self-efficacy can occur (i.e., exposure to complexity, turning inward, and taking action). Additionally, it is discussed that a decrease in members’ self-efficacy could be a favorable result. The more awareness they have surrounding GT, the more realistic their understanding and approaches are. This was revealed in the other themes of deepened awareness, intentional community, and “abnormalizing” the abnormal. Overall, this study has promising implications for individuals, communities, counselors, counselor educators, and future research.
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APPENDICES

Table 1: Member Demographics

Table 2: Study Timeline and Overview

Table 3: Summary of Themes and Sub-Themes by Research Questions

Figure 1: Concept Map Depicting Research Questions and Their Associated Themes

Appendix A: Recruitment Flyer

Appendix B: Trauma History Questionnaire

Appendix C: New General Self-Efficacy Scale

Appendix D: Interview Protocol
  
  Appendix D.1: Pre-Individual Interview Protocol
  
  Appendix D.2: Focus Group Interview Protocol
  
  Appendix D.3: Post-Individual Interview Protocol

Appendix E: Support Group Curriculum

Appendix F: Generational Trauma and Healing “Quilts”
Table 1

Member Demographics

<table>
<thead>
<tr>
<th>Study Number</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Religion/Spirituality</th>
<th>Geographic Region</th>
<th>Highest Education</th>
<th>Occupation</th>
<th>Relationship &amp; Parenting</th>
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</thead>
<tbody>
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<td>1</td>
<td>33</td>
<td>AA, African</td>
<td>Christian</td>
<td>Southwest</td>
<td>Master’s</td>
<td>Doctoral student in clinical psychology</td>
<td>Single; No children</td>
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<tr>
<td>2</td>
<td>26</td>
<td>AA</td>
<td>Christian</td>
<td>Southeast</td>
<td>Master’s</td>
<td>Contact tracer for Department of Public Health</td>
<td>Engaged then Married; 1 child</td>
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<td>3</td>
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<td>AA, Hispanic</td>
<td>Christian</td>
<td>West</td>
<td>Master’s</td>
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<tr>
<td>4</td>
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<td>Christian</td>
<td>Southeast</td>
<td>Master’s</td>
<td>Public health strategy consultant</td>
<td>Single; No children</td>
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<td>5</td>
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<td>Christian</td>
<td>Southeast</td>
<td>Bachelor’s</td>
<td>Homemaker</td>
<td>Married; No children</td>
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<td>6</td>
<td>28</td>
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<td>Christian</td>
<td>West</td>
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<td>Assistant professor</td>
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<td>West</td>
<td>Bachelor’s</td>
<td>Nonprofit project manager</td>
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<tr>
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<td>AA, CA</td>
<td>Christian</td>
<td>Northeast</td>
<td>Master’s</td>
<td>University instructor</td>
<td>Committed relationship; No children</td>
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</table>

*Note.* “AA” denotes African American, “CA” Caribbean American, “MFT” marriage and family therapy, and “DEI” diversity, equity, and inclusion

Table 2

Study Timeline and Overview

<table>
<thead>
<tr>
<th>Survey</th>
<th>Individual Interview</th>
<th>Focus Group Interview</th>
<th>Support Group Meeting</th>
<th>Data Analysis</th>
<th>Research Team Meeting</th>
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<td>Week 1</td>
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Note. “X” indicates that the study component occurred during the corresponding week.
### Table 3

**Summary of Themes and Sub-Themes by Research Questions**

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<thead>
<tr>
<th>Research Question</th>
<th>Theme</th>
<th>Sub-Themes of Individual and Group Processes</th>
<th>Sub-Themes of Familial and Societal Factors</th>
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<tr>
<td>RQ1</td>
<td>Deepened Awareness</td>
<td>Imparting information</td>
<td>Awareness of transgenerational processes in families and communities</td>
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<td>Interpersonal learning</td>
<td>Existential queries</td>
</tr>
<tr>
<td>RQ1</td>
<td>Intentional Community</td>
<td>Group cohesion: Norms, vulnerability, linking, and humor</td>
<td>Cliques and ostracization</td>
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<td></td>
<td></td>
<td>Participatory, egalitarian group facilitation</td>
<td>Unofficial family roles</td>
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<tr>
<td></td>
<td></td>
<td>Challenging one another to make positive changes</td>
<td>Contingent support and dependability</td>
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<tr>
<td>RQ1</td>
<td>“Abnormalizing” the Normal</td>
<td>Universality “Big T” versus “little t” trauma</td>
<td>Dismissive of constructive dialogue</td>
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<td></td>
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<td>Anticipating avoidance</td>
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<td>RQ2</td>
<td>Exposure to Complexity</td>
<td>Changes in self-efficacy</td>
<td>Changes in definitions of GT and healing</td>
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<td>RQ2</td>
<td>Turning Inward</td>
<td>Self-accountability</td>
<td>Non-dichotomy of experiences</td>
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<td></td>
<td></td>
<td></td>
<td>Distancing for peace and clarity</td>
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<tr>
<td></td>
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<td>Shifting focus from previous generations to self and future generations</td>
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<tr>
<td>RQ2</td>
<td>Taking Action</td>
<td>Group activities: Genogram, skill-building, letter-writing, role plays, and quilts</td>
<td>Applying insights/skills learned in group</td>
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<tr>
<td></td>
<td></td>
<td>Participating and showing up even when difficult</td>
<td>Mending relationships</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Disrupting maladaptive processes</td>
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</table>
Figure 1

*Concept Map Depicting Research Questions and Their Associated Themes*
Appendix A

Recruitment Flyer

Got generational trauma? Let's connect.

Starting March 2022

Project Heal Generational Trauma
A Virtual Support Group & Research Study Of, By, & For Millennial Black Women

Generational trauma is the effects of trauma that are passed down between generations in families and communities.

Eligibility for participation:
1. Millennium (i.e., born between 1981-1994)
2. Black or of African descent
3. Woman (i.e., gender or trans)
4. Have familial generational trauma
5. Have strong internet connection to support Zoom meetings
6. Commit to 2 surveys, 2 individual interviews, 1 focus group, & 8 weekly meetings with other millennium Black women. (A total of 11 hours & 40 minutes)

Days and times will be determined once all participants are selected to accommodate for everyone’s schedules.

Interested in participating? Fill out the Initial Survey

For more information, email Ashlei Peterson at asb0023@student.gsu.edu or DM @counselorashlei on Instagram or Twitter.

Note: Initial Survey Link: https://gsu.qualtrics.com/jfe/form/SV_3gUIlIAJQkvA6G2
Appendix B

Trauma History Questionnaire

The following is a series of questions about serious or traumatic life events. These types of events actually occur with some regularity, although we would like to believe they are rare, and they affect how people feel about, react to, and/or think about things subsequently. Knowing about the occurrence of such events, and reactions to them, will help us to develop programs for prevention, education, and other services. The questionnaire is divided into questions covering crime experiences, general disaster and trauma questions, and questions about physical and sexual experiences.

For each event, please indicate whether it happened and if it did, the number of times and your approximate age when it happened (give your best guess if you are not sure). Also note the nature of your relationship to the person involved and the specific nature of the event, if appropriate.

Crime-Related Events

(1) Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick-up or mugging?

(2) Has anyone ever attempted to rob you or actually robbed you (i.e., stolen your personal belongings)?

(3) Has anyone ever attempted to or succeeded in breaking into your home when you were not there?

(4) Has anyone ever attempted to or succeed in breaking into your home while you were there?

General Disaster and Trauma

(5) Have you ever had a serious accident at work, in a car, or somewhere else?
(6) Have you ever experienced a natural disaster such as a tornado, hurricane, flood or major earthquake, etc., where you felt you or your loved ones were in danger of death or injury?

(7) Have you ever experienced a “man-made” disaster such as a train crash, building collapse, bank robbery, fire, etc., where you felt you or your loved ones were in danger of death or injury?

(8) Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health?

(9) Have you ever been in any other situation in which you were seriously injured?

(10) Have you ever been in any other situation in which you feared you might be killed or seriously injured?

(11) Have you ever seen someone seriously injured or killed?

(12) Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any reason?

(13) Have you ever had a close friend or family member murdered, or killed by a drunk driver?

(14) Have you ever had a spouse, romantic partner, or child die?

(15) Have you ever had a serious or life-threatening illness?

(16) Have you ever received news of a serious injury, life-threatening illness, or unexpected death of someone close to you?

(17) Have you ever had to engage in combat while in military service in an official or unofficial war zone?

Physical and Sexual Experiences

(18) Has anyone ever made you have intercourse or oral or anal sex against your will?
(19) Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat?

(20) Other than incidents mentioned in Questions 18 and 19, have there been any other situations in which another person tried to force you to have an unwanted sexual contact?

(21) Has anyone, including family members or friends, ever attacked you with a gun, knife, or some other weapon?

(22) Has anyone, including family members or friends, ever attacked you without a weapon and seriously injured you?

(23) Has anyone in your family ever beaten, spanked, or pushed you hard enough to cause injury?

(24) Have you experienced any other extraordinarily stressful situation or event that is not covered above?

**Generational, Cultural, and Historical Trauma**

(25) Has anyone in three generations of your family experienced the death of a child?

(26) Has anyone in three generations of your family experienced abuse or domestic violence?

(27) Has anyone in your family lost a significant piece of their cultural heritage due to genocide, slavery, or other forceful means?

(28) Has anyone in three generations of your family experienced divorce?

(29) Has anyone in three generations of your family spent a portion of their life in poverty?

(30) Is there a topic in your family that family members aren’t allowed to talk about because it’s too upsetting to someone?

(31) Has anyone in three generations of your family experienced a hate crime, racism, or stigmatization?
(32) Has anyone in three generations of your family experienced sexual violence?
(33) Has anyone in three generations of your family immigrated to a new country?
(34) Has anyone in three generations of your family experienced addiction or substance misuse?
(35) Has anyone in three generations of your family gone into active combat or sent a family member into active combat?
(36) Has anyone in three generations of your family been estranged from someone they loved?
Appendix C

New General Self-Efficacy Scale

The following statements are used to determine your self-efficacy, or the belief in your ability to address generational trauma in your family. Choose from the following options to select for each item: strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, strongly agree.

(1) I will be able to achieve most of the goals that I set for myself.
(2) When facing difficult tasks, I am certain that I will accomplish them.
(3) In general, I think that I can obtain outcomes that are important to me.
(4) I believe I can succeed at most any endeavor to which I set my mind.
(5) I will be able to successfully overcome many challenges.
(6) I am confident that I can perform effectively on many different tasks.
(7) Compared to other people, I can do most tasks very well.
(8) Even when things are tough, I can perform quite well.
Appendix D
Interview Protocol

Appendix D.1: Pre-Individual Interview Protocol

A. General demographic, identity, and family of origin information
   a. Researcher will provide qualitative summary of interest form submission. Is there anything you would like to add or change to this information that we should know about you?
   b. What motivated you to join the group?

B. Pre-survey results report and discussion
   a. Researcher will provide summary of pre-survey results. You scored in the ____ range. Is this score an accurate representation of how you feel? Why or why not?
   b. If you could add any questions to the pre-surveys that would help us get to know you better, what would they be and why?

C. GT experiences and perspectives
   a. What are the top 2 GT issues that plague your family of origin? How do these issues affect you personally?

D. Hopes and fears for the group
   a. What are you hoping to gain from this group? From other group members? For yourself?
   b. What worries you about the group? What would help to ease those concerns?

Appendix D.2: Focus Group Interview Protocol

A. General reflections, new knowledge, and comments about the group so far
a. On a scale of 1 to 10, how would you rate your enjoyment of the group thus far? The safety? The effectiveness in relation to the overall goal?

b. What have you learned so far? What do you feel like you still need to learn?

B. Revisiting hopes and fears from individual interviews

a. What hopes did you have initially that have since been fulfilled? Which hopes have not yet been fulfilled? What do you attribute this to?

b. Have any of your fears come true? If so, how? If not, what do you attribute that to?

C. What constructive feedback do you have for the research team, including each other?

a. What are we doing well?

b. What could we improve upon? What is missing from the group?

Appendix D.3: Post-Individual Interview Protocol

A. Post-survey results report and discussion

a. Researcher will provide summary of post-survey results. You scored in the ____ range. Is this score an accurate representation of how you feel? Why or why not?

b. Researcher will provide comparison of pre- and post-survey results. What do you make of seeing your scores together? What do you attribute the change and/or consistency to?

B. GT experiences and perspectives

a. At the beginning of our group, you identified the top 2 GT issues that plague your family of origin as ____ and ____. You also reported that they affected you personally, for example: ____. What is it like to hear these things at the end of our
group? How has your participation in the group impacted how you feel about these issues? How you approach them?

C. Addressing GT within family of origin
   a. How have your family relationships changed since joining the group? How have they remained the same?

D. What constructive feedback do you have for the research team?
   a. What was the most useful activity for you? Why?
   b. If we were to run this group study again in the future, what could we do differently to improve?

E. Hopes for the future
   a. Moving forward, I am confident in my ability to ___.

Appendix E

Support Group Curriculum

Week 1: Introductions, Rapport-Building

- Check-in: Welcome and group introductions. Share the origin of all your names (i.e., first, middle, and last; how and why you were given those names or how you chose them, if applicable). Additionally, share whether you would change any of your names.

- Activities:
  - Facilitators guided members in setting the group norms to be followed for the duration of the group.
  - Facilitators shared anonymous, visual compilation of ‘hopes and fears’ for the group (extracted from members’ individual interviews) and prompted a discussion.
    - Which hopes/fears resonate with you the most?

- Check-out: Explanation of homework for Week 2

  - Homework:
    - Prepare two strengths and two areas for growth within your family related to GT. (Facilitators shared their responses as modeling.)
    - Bring a “comfort item” for “show and tell” for Week 2.

Week 2: Exploring GT

- Check-in: Members and facilitators shared their “comfort items” along with a brief explanation.

- Process observations discussion

- Activities:
Members shared their two strengths and two areas for growth within their families related to GT.

What is GT? A formal definition of GT was provided, and a discussion was facilitated.

- What does GT look like? (i.e., “If we had a camera inside your home, what would we see?”)
- What does GT feel like? (i.e., “If we were inside of your head or heart, or like the movie “Inside Out”, what would we feel?”)

Check-out: Explanation of homework for Week 3

- Homework: Construct a 3-4 generation family genogram, identifying patterns of trauma, relationships, and other processes relevant to your family (e.g., education, incarceration, substance misuse, etc.). A facilitator shared her genogram as an example.

**Week 3: Exploring GT through Genograms**

- Check-in: Welcome and general check-in
- Process observations discussion
- Activities:
  - Facilitators generated an open discussion about members’ family genograms.
    - How was this activity for you?
    - What was something you learned about yourself or your family?
    - What questions do you still have? (i.e., gaps in genogram, application to self, etc.)
  - Trauma vs. trauma
• Check-out: Share something you will do to take care of yourself between this meeting and the following meeting, and to sign up for a focus group time slot.
  ○ Homework: None

**Week 4: Skill-Building for Generational Healing: Interpersonal Communication**

• Check-in: Share an update on what you did for self-care since the last group meeting.
• Process observations discussion
• Activities:
  ○ Facilitators shared various communication skills for challenging conversations about GT (e.g., save the conversation for a calm moment, gentle body language and tone of voice, “I” statements to express how you feel, describe the problem clearly, and being respectful). A discussion was facilitated.
    ▪ Which of these skills do you find most challenging for you? For others in your family?
• Check-out: Name a color that you would associate with how you’re feeling right now.
  ○ Homework: Using the communication skills discussed in this meeting, write a letter to someone who you miss, someone who you’re frustrated with, or to someone with whom you want to share something. You do not have to share it with them.
  ○ Reminder about attending focus group interviews between this meeting and the following meeting.

**Week 5: Practicing Skills for Addressing GT**

• Check-in: Five senses grounding exercise
• Process observations discussion
Activities:

- Homework reflection discussion: What was this experience like for you?
  
- Role play: Facilitator shared her letter from previous week. A volunteer group member portrayed the letter recipient. The two engaged in a role play, with the facilitator demonstrating the use of the interpersonal communication skills for generational healing, and the member portraying the role of the letter recipient.
  
  - Debriefing: What was it like to be part of the role-play? Name an emotion word and provide a brief explanation. What was it like to listen to the role play, from the outside looking in? Name an emotion word and provide a brief explanation.

- Check-out: Self-compassion exercise. Share an emotion word of how you’re feeling followed by an affirmation or encouraging statement (e.g., “I’m having a rough time, but I am doing my best and I’ll make it through.”)
  
  - Homework: None

Week 6: Practicing Skills for Addressing GT Part II

- Check-in: A member shared a song that she recorded, representing her tumultuous relationship with a family member. A brief discussion followed.
  
  - Which lyrics resonated with you the most? Which lyrics evoked notable emotions within you?
  
  - What other songs represent GT and/or generational healing to you?

- Process observations discussion

- Activities:
Members were invited to share their letter and engage in a role play. Afterwards, an open discussion was prompted.

- How does this letter/role play apply to you and your loved ones?

- Check-out: Self-compassion exercise. Share an emotion word of how you’re feeling followed by an affirmation or encouraging statement (e.g., “I’m having a rough time, but I am doing my best and I’ll make it through.”)

  - Homework: None

**Week 7: Open Discussion and Reflections on GT**

- Check-in: Brag on yourself! Share a recent accomplishment, small or large.

- Activities:
  
  - Per last week’s feedback, members were engaged in an open discussion on generational trauma. Dialogue included reflections of skill-building and practice, connections with other members, and hopes for the future.

- Check-out: Share one positive change in your life since joining the group.

  - Homework: Post-survey, sign up for post-individual interview, and email facilitators your personal definitions of generational trauma and generational healing.

**Week 8: Open Discussion and Reflections on Boundaries and Generational Healing, Termination**

- Check-in: Co-facilitators shared a visual compilation of the members’ personal definitions of GT and generational healing in the form of a virtual quilt, as described by the tenets of BFE. Members reacted to the quilts.

- Process observations discussion
• Activities:
  o Per last week’s feedback, members were engaged in an open discussion on boundaries as they relate to GT and healing. Dialogue included reflections of skill-building and practice, connections with other members, and hopes for the future.

• Check-out:
  o Brief overview of the entire course of the group, highlighting progress, changes, and memorable moments from the group process.
  o Share a personal strength and area for growth as a connection to the first homework assignment, and reflection of group members’ expression of generational healing starting within.
  o Homework: Attend post-individual interview.
Appendix F

Generational Trauma and Healing “Quilts”

Generational Trauma “Quilt” of Member Definitions

<table>
<thead>
<tr>
<th>事件</th>
<th>定义</th>
<th>影响</th>
<th>症状</th>
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</thead>
<tbody>
<tr>
<td>A negative event or events that are perpetuated within a family that cause an individual to psychological or physical distress</td>
<td>The passing of collective trauma, via genetics and ancestral memory, throughout a family’s lineage</td>
<td>The emotional and psychological effects of unhealthy situations and coping mechanisms passed down</td>
<td>Events (physical, mental, social, emotional, etc.) that are evident in and span across multiple generations of a family that severely impact the actions of generations that follow</td>
</tr>
<tr>
<td>Carrying on the pain and hurt from one family member to the other time over time</td>
<td>GENERATIONAL TRAUMA</td>
<td>Unhealed and unprocessed trauma that impacts and effects one generation to the next</td>
<td>Mental or physical ailments that are passed down by nature or nurture in a family</td>
</tr>
<tr>
<td>Experiences of trauma or trauma-related responses passed down through generations that tend to create additional traumatic experiences for subsequent generations</td>
<td>Highly stressful event, lifestyle, or mindset that is passed down from generation to generation of family or family-like units through</td>
<td>Trauma from certain life events in one generation that is passed down through different generations until healed</td>
<td>The transmission of the effects across generations through parenting, socialization, and lack of intentional intervention</td>
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Generational Healing “Quilt” of Member Definitions

<table>
<thead>
<tr>
<th>活动</th>
<th>定义</th>
<th>影响</th>
<th>症状</th>
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<tbody>
<tr>
<td>Working collectively to restore, repair damages caused by familial hurt in various forms including psychological, emotional, and physical</td>
<td>The breaking of past traumatic cycles within a family’s lineage with the goal of preventing the cycles from continuing</td>
<td>Becoming aware of the generational trauma and beginning to acknowledge how it affects us so positive change can begin</td>
<td>Acknowledging the trauma that exists across generations and actively working through it to decrease the likelihood or burden on future generations</td>
</tr>
<tr>
<td>Learning how to forgive one another</td>
<td>GENERATIONAL HEALING</td>
<td>Healing that takes place in an individual to break generational patterns. This healing can help future generations and also foster healing and growth in older generations</td>
<td>When that chain is disrupted from one generation to the next</td>
</tr>
<tr>
<td>Working on trauma-related responses and developing healthy coping mechanisms and healthy communication skills in order to prevent future traumatic experiences for younger generations; Addressing previous conflict to move forward and create healthier relationships</td>
<td>Steady progress of becoming healthy seen through generations of family or family-like units typically starting with the youngest generation</td>
<td>When a generation heals trauma within their family and ends it from continuing, trauma can be healed through various means</td>
<td>An ongoing, intentional process of healthy communication, forgiveness, and individual and collective growth in order to interrupt the transmission of the effects of trauma</td>
</tr>
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</table>