FACILITATING FAMILY AND COMMUNITY RESILIENCE
IN RESPONSE TO MAJOR DISASTER

Judith Landau and Jack Saul

INTRODUCTION

This chapter examines the devastating psychosocial impact of major disasters and the capacity of families and communities to forge resilience in the wake of trauma and loss. We then describe the LINC Community Resilience model (Landau-Stanton, 1986; -1990; Landau, 1991; -2003), and its applications for individual, family, and community recovery in the aftermath of major disaster, with a primary focus on two projects: (1) Lower Manhattan Communities following the 9/11 terrorist attacks, and (2) impact of political and economic instability and "disappearances" of dissidents in Buenos Aires, Argentina. Within the concept of community, we regard the family as the integral unit of change. In addressing community, we refer to the individuals, families and social organizations within it, their history, culture, economy and physical environment.

Our approach to family and community recovery from major disaster is grounded in a resilience metaframework. The concept of resilience—strengths and recovery in the context of crisis and adversity-- was first applied to the individual child or adult, and more recently to families (for a review of major research see Walsh, 1996). Most relevant to the impact of major disasters are studies of resilience in children living in war zones and those navigating urban violence (Bell, 2001; Garbarino, 1992; and Garbarino & Kostelny, 1996). Other studies have examined family stress and coping in the wake of major trauma and loss (such as Boss, 1999; 2003; Danieli 1985; 1985; Figley, 1996; Figley & McCubbin, 1983). Our own practice model broadens the concept of resilience to the level of larger systems, or communities (Auerswald, 1983). Recent reviews of research on disaster point to the central role of psychosocial resources in accounting for resilience and protecting disaster victims' mental health (Norris et al., 2003), and support a community resilience approach as the most effective form of intervention (Padgett, 2002).

Walsh (2003) defines resilience "as the capacity to rebound from adversity, strengthened and more resourceful. It is an active process of endurance, self-righting, and growth in response to

crisis and challenge…the ability to withstand and rebound from disruptive life challenges." (p. 4). At the simplest level, we define community resilience as a community's capacity, hope and faith to withstand major trauma and loss, overcome adversity, and to prevail, usually with increased resources, competence and connectedness (Landau, 2001; Saul, 2002). We see this as an inherent competence present in us all. For the human spirit to prevail and be perpetuated across generations, we need to be able to access and utilize our biological, psychological, social and spiritual resources to cope with the impact and immediate consequences of trauma, and to be able to promote long-term recovery and healing (Landau, 1982).

TRANSITIONAL PATHWAYS, CONNECTEDNESS, AND RESILIENCE

In the '70s in South Africa the first author (JL) was asked to teach a group of black Presbyterian ministers how to counsel and serve the couples and families in their parishes. When she asked them to draw their family genograms not one was able to go back further than two generations--they had no idea where they came from. The influence of rapid urbanization had disrupted their communities, traditions and rituals, as well as their knowledge of family history and structure. In the tribal situation, the elders and the storytellers had passed on the family and cultural stories and rituals, but in the cities, the tradition had broken down. Parents in the tribe were responsible primarily for discipline, not for continuity of the oral tradition and the richness of intergenerational stories.

There was, in effect, a disconnection and discontinuity of their **transitional pathway** that connects people in smooth transition, creating continuity among past, present, and future, bridging their entire ecosystemic context. As a result, they had lost access to their inherent competence and resilience: strengths and resources that their families and tribe had been able to access and utilize across time (Landau-Stanton, 1990). When people are able to access past resilience by being in touch with their history, they can reconnect their transitional pathways, knowing where they came from and where they are now. This enables them to recognize and utilize biological, psychological, social, and spiritual resources. They can make informed choices about what to keep from their past to draw on for the future and what to leave behind. Such choices allow them to plan where to go and how to get there. This process of **reconnection, continuity, and recalibration** mobilizes the transitional pathway over many generations forward into the future. It allows families and communities to access their inherent competence

and resilience in order to deal with potentially overwhelming situations (Landau-Stanton & Clements, 1993).

A major polarity in this process is dissociation and disconnection *versus* attachment and/or connectedness. Applying this framework to examine how families and communities access and maintain resilience and health across time, a series of studies (Landau et al., 1995; 2000; Tuttle, et al., 2004) explored the impact of positive attachment or connectedness to family and culture of origin. For example, in examining sexual risk-taking behavior we found that the greater the connectedness, the less likely was the risk-taking (Landau, Cole, et al, 2000), as measured by knowledge of intergenerational family stories and frequency of contact. In a subsequent study of adolescent girls with a range of diagnoses in a mental health clinic, qualitative analysis of their stories for themes of resilience (overcoming adversity) versus vulnerability (e.g. depression, family violence, addiction) revealed that knowing any story, even those with themes of overwhelming vulnerability, was more protective than knowing none at all (Tuttle et al, 2004).

Numerous studies have demonstrated that connectedness to family, school, and culture is protective against risk-taking of many kinds, promotes and maintains health, and diminishes the likelihood of illness (CASA, 2003; Gavin, et al., 1999; Grotevant & Cooper, 1998; Igra & Irwin, 1996). Similarly, from Bowlby's (1969, 1988) pioneering work on attachment to more recent studies (Klingman & Cohen, 2004, research has shown that increased social support and secure attachment decrease the risk of major sequelae of trauma and increase access to internal and external resilience. Therapists can help families to restore transitional pathways and build positive connectedness to counter destructive forces for healing and resilience. (Landau, 1990; Landau & Garrett et al, 2000; Landau & Cole et al, 2000; Suddaby & Landau, 1998).

1. **FAMILY & COMMUNITY RESILIENCE IN RESPONSE TO MAJOR DISASTER**

We define major disaster as catastrophic or cataclysmic events that result in major disruption and/or massive and unpredictable loss (Landau 2001; 2003). The level of impact of major disaster differs widely depending on several factors. For example, in the case of New York's Twin Towers on September 11th, 2001, the trauma was dramatically increased by the unpredictability of the event, that it was beyond the imagination of most people, and that it shattered their basic assumptions about the world in general, and their own identity and

environment in particular. It affected so many people because it was witnessed as it was occurring, not only by local residents, but also by television viewers worldwide.

In order to illustrate the LINC approach to facilitating community resilience in response to major disaster, we have identified some key factors in disruption and recovery that we discuss briefly below:

(1) Disruption of Family and Community Systems: Process, Function, Structure and Organization

In exploring the impact of disconnectedness, or disruption of families and communities, Durkheim (1897) noted that "When society is disturbed by major crisis, the resulting disequilibrium renders it temporarily incapable of exercising its usual regulatory function." (in Landau, 2001). A glaring example is that of countries after war. While working in Kosovo at the end of the 1999 war and in its aftermath, we observed that new structures had to be put in place from the ground up because very little remained of the old systems. There was a major episode of vendetta killing, with no legal system to deal with it and only a peacekeeping force with minimal authority. The population was left exposed to the terror and violence from rising crime. This lack of structure creates a vulnerability to the impact of the trauma, resulting in common sequelae of trauma, e.g., post-traumatic stress disorder, depression, suicidality, addiction, HIV/AIDS, and domestic and community violence. The inaccessibility of prior social patterns increases the necessity for transformation and the emergence of new social patterns to meet the demands of new realities.

(2) Transitions as Stressors

Change and transition are inevitable in human and societal development. Change and timely loss (e.g., death of an elder) occur in normal development in individual and family life cycles. Three or more changes or transitions, even if expected and "normal," are likely to result in stress. Stress is precipitated by the disruption of the transitional pathway, with increased risk that problems and symptoms will develop at individual, family and community levels. The more rapid and numerous the transitions are, the greater the impact of the disruption will be (Boss, 2001; Carter & McGoldrick, 1999; Garmezy and Rutter, 1983; Landau-Stanton, 1990)

During major upheaval, such as massive trauma, the coordinated movement of individuals, families and communities is disrupted. This loss of coordination results in individuals and families, or other subsystems of the community, moving in different and unpredictable directions and at different rates of change. The result is an asynchrony of the normally smooth functioning

4

of the transitional pathway. This asynchrony, or transitional conflict, and the resulting disconnection appears to be directly responsible for the development of symptoms and/or major problems (Landau, 1982).

(3) Catastrophic or Overwhelming Stressors and Transitions: The Impact of Unresolved Grief and Loss and the Emergence of Resilience

There was a dramatic rise (31%) in the rate of substance abuse and addiction in New York City after September 11th, 2001 (CASA, 2003; Department of Health, NYC, 2002). To understand this phenomenon, we can go back to a British concentration camp in South Africa 100 years ago (Landau & Stanton, 2003).

Thirteen children watched their grandmother and mother being killed. Only three survived. After the war, the three siblings stayed together and two began drinking heavily, while the oldest married and took care of them for the rest of their lives. The unresolved grief from their untimely, catastrophic, and unpredictable loss resulted in their remaining close together and never properly being able to complete the life cycle transition of leaving home. They all stayed together, protected from suffering any further losses. After three generations of addiction problems, the grief lessened and was resolved with the passage of time. The 4th generation has been able to move on to healing and health.

In studying the intergenerational history of families struggling with addiction, we invariably find massive, unpredictable loss and unresolved grief at the onset of the addiction (Landau & Stanton, 2003; Stanton & Landau, 2003). The addictive behavior is an attempt to adapt to disruption of the family unit. It draws the family's attention away from the grief, and the constant needs of the addicted person and failure to leave home successfully bind the family together. Typically 3-5 generations later the connectedness and sharing of love and mutual support result in a sense of security and trust allowing a new generation to emerge that no longer needs the adaptive pattern that had long ago become redundant and dysfunctional. The grief has been resolved as in the concentration camp case above. In this way, families and communities draw on their resilience to adapt in the immediate aftermath of major loss and trauma, finding mechanisms to maintain connectedness to assuage grief. An adaptation that was initially "successful" is then perpetuated. Addiction also illustrates the capacity of families to move into self-healing by accessing their resilience across generations.

Addiction is only one of the dysfunctional outcomes of overwhelming loss. The disruption of routines, rituals and structure in the family and community also result in a marked increase of violence and abuse in refugee families and others who have been uprooted by massive trauma (Bentovim, 1995; Sheinberg and Fraenkel, 2000). We also see, as in Taiwan after major earthquakes and floods, a significant (60%) increase in the rates of depression and suicidality (Lee, 2002).

(4) The Impact of Major Disaster on Family Dynamics

This type of massive assault on the family, resulting in numerous transitions within a very short time, inevitably results in transitional conflict. This is accentuated in untimely transitions, or reversals of the normal direction and pace of the family life cycle (Landau-Stanton & Clements, 1993). One example, seen frequently during massive trauma, is that of the child who has lost one or both parents and must become prematurely self-reliant and responsible for others. If a parent is missing or dead, a cross-coalition with the other parent can lead to parentification of the child. While the parent, or other significant family member is missing, a situation of ambiguous loss disrupts family functioning as members are in limbo (Boss, 1999; see Chapter 11). When this occurs with multiple families in a community, the result can be disastrous and affect every level of daily functioning. Should the missing parent reappear, serious conflict is inevitable. If the parent or another significant family member is dead, the power of that loss is extreme and, again, is multiplied across the community in situations of massive trauma.

"Some families are able to….share the experience of their pain from loss. They are able to bridge life and death by planning for the future with the help of their dying loved one, say good-bye to the deceased, and punctuate this life cycle event in a meaningful way" (Horwitz, 1997. p 212). However, in the case of unpredictable loss, as is common in times of massive trauma when this preparatory work cannot be done, it precipitates an inevitable transitional conflict with severe stress and its sequelae.

(5) Changes in Bonding Patterns

Perhaps the most powerful dynamic in families that have endured massive loss and trauma revolves around issues of separation. In families of Holocaust survivors, for example, the over-involved relationship between parents and children is intensified by a number of factors that complicate age appropriate separation: mutual overprotection, lack of role differentiation, binding behaviors, distorted communication, and undermining of autonomous functioning. Survivor parents who were not able adequately to mourn the deaths of family members may

suffer from a deep sense of emotional deprivation, suppressed grief, and delayed mourning. This makes it difficult for them to tolerate the loss created by separation from their own children. (Perel and Saul, 1989).

(6) Loss of Ability to Contextualize:

Clark and colleagues (2003) examine the interface of working memory and brain function during traumatic situations. One needs to be able to shut off immediate memory in order to have access to other memories that contextualize what is happening. When people are traumatized, they don't contextualize well because the disrupted communication around the events--their isolation and silence—interferes with normal cognitive and biological processes.

(7) Impact on Communication Patterns:

Danieli (1985) describes how a conspiracy of silence may be perpetuated after massive loss and trauma, as in the case of the Holocaust. A collusion between therapists and patients, society and survivors, and among family members to avoid speaking about traumatic events may lead to gaps in one's experience of the world and sense of historical continuity, and may increase the disconnection of families and communities. Adult children of Holocaust survivors often use the term "osmosis" to refer to the verbal and non-verbal ways that parents' Holocaust experience was communicated to them and to describe its omnipresence in their families. In our work with families of torture survivors, survivors of terrorist attacks, and families of the "disappeared" (political dissidents) in South America, we have noticed the double message communicated to children as their parents speak about traumatic experiences in their presence while instructing them not to hear. In contrast, we have also experienced poignant examples of the positive aspects of communication:

> While teaching in Kosovo, we were asked to consult to a man suffering from intractable depression. At first glimpse, as he limped slowly into the room, he appeared to be extremely "old and broken."   As his story emerged, we began to understand. He had watched thirty-seven men of his village (most members of his extended family) being massacred in front of their women and children. He and two cousins survived and, while in prison, he heard their dying screams, not understanding why he had been spared. He realized that he could no longer farm the land and began to despair about his survival and reason for living. We discussed how he could serve his remaining family and village. He agreed to become the link therapist, coached by the Kosovar Mental Health Professional Team, to work with the villagers to remind them of their stories of resilience; their

generations of strengths and survival. He realized that he did not need to be physically fit to teach the children to love and not to hate and that he had a reason for staying alive.

Similarly, in rural Albanian Kosovar families in which the adult men and teenage boys were murdered, interventions that facilitated communication among the surviving elders and the children of the family were important in promoting a sense of historical continuity and ensuring that the stories of resilience would not die. (Saul, et al., 2003).

(8) Impact on the Social Level:

Chemtob & Taylor (2002) describe an evolutionary model of trauma response, survival mode theory, proposing that two systems become activated in a disaster or experience of overwhelming stress. The first is the threat detection system, i.e., people are physiologically aroused and hypersensitive to cues that signal danger in the environment. The second is the affiliative system that leads to social bonding and group cohesion. The activation of these two systems is adaptive in the first phase after a disaster, but once the danger has subsided, people may not be able to modulate affect and return to a normal state of arousal, retreating into smaller subsystems where they feel safe. This social fragmentation is an example of an adaptation that was initially useful for survival but becomes dysfunctional when perpetuated across time.

(9) Impact of Major Disaster on Family and Community Resources:

Just as asynchrony disrupts the family and community, it also causes major problems in the recognition, accessing, and utilization of resources. According to Conservation of Resource theory (Hobfoll, 1988; 1989), people strive to obtain, retain, and protect that which they value. Stress occurs when people lose their resources, are threatened with their loss, or are unable to develop or enhance resources despite significant effort. Following extremely stressful events, those with fewer resources are more deeply impacted and less able to mobilize the community as a whole. The community generally has hidden reserves, or resources that, when shared, offer additional support and strength to individuals and families. Mutual support efforts can reduce the impact of severe loss, allowing people to support themselves in their recovery process.

(10) Reconnecting the Transitional Pathway:

Resilience is demonstrated by the ability to resynchronize, reconnect, the transitional pathway, and mobilize the strengths discussed above. Post-traumatic growth is a measurable, concrete expression of resilience in action—an illustration of the inherent strength and competence of the human spirit (Calhoun and Tedeschi, 1999). Families and communities have

the inherent capacity to heal. It is this capacity that we need to mobilize to deal with the impact and aftermath of massive trauma.

II. FAMILIES & COMMUNITIES CONFRONTING DISASTER

To sum up, our approach to families and communities is based on the assumptions that they are intrinsically healthy and competent; that people and environments are constantly in transition and that, over time, they will find and utilize their competence. Their competence becomes unavailable when they are cut off from their extended support system and resources. In order for them to access this intrinsic competence, they need to be able to retain or regain connection to their families and natural support systems, their daily patterns and rituals, their sense of meaning, their spiritual support system and their culture (Landau, 1982, Landau-Stanton, 1986; Landau-Stanton & Clements 1993).

In times of massive trauma, these primary connections are disrupted. In addition, those who have been most impacted by the trauma are frequently regarded as different, or less capable, than those who come "to help." A "we/they dichotomy" develops that makes it even more difficult to regain the seamless connectedness that is the basic fabric of a well-functioning family and community.

Assessing the Situation

How do we recognize resilience in traumatized families and communities in traumatic situations? How does it present? How do we gain an understanding of where families and communities are during or after major disaster? What are the conditions under which resilience emerges from loss? How do people demonstrate being overwhelmed by vulnerability? Or show their sense of optimism, despite horrendous situations? How do we know whether resources are available to them, or have been hopelessly depleted? How do we know they're accessing those resources, if present? How do they demonstrate their connectedness to their families, culture and community? How do we know when a community is conserving resources by its carefully considered inactivity, rather than demonstrating a lack of resilience and energy to heal?

Because we see the family as the primary unit of change within the community, in addressing these questions we need to be cognizant of the situation of the families within the traumatized community and view them as the yardstick of trauma and healing. The criteria discussed in Section I above provide our framework for family assessment (see also Horwitz, 2001; and Watson & McDaniel, 1998 for assessment guidelines using Transitional Family Therapy).

Strategies For Understanding Communities

There are numerous strategies for exploring community process, structure, organization and function. The broad categories that we use are survey research, ethnographic interviewing (Weine, 1999), and community action research that is the closest to our LINC Community Resilience methods. The process is one of training, assessment, research, intervention, empowerment and evaluation, not necessarily in that order. The following case examples will illustrate some of our principles and working methodology.

Case Example 1: The Lower Manhattan Communities after September 11, 2001

The communities that we are concerned with are located on the west side of Lower Manhattan just next to the World Trade Center site, in the neighborhoods of Tribeca and Battery Park City. These were the children, teachers, parents, residents and workers who experienced the greatest physical exposure to the events of 9/11, including witnessing the planes crashing into the towers, the buildings burning and collapsing, and people jumping/falling to their deaths; the disappearance and deaths of friends and family members; direct threat to life and harm from the debris storms; emergency evacuations from workplaces and schools; displacement from home, school and business, and environmental contamination. Additionally, in the aftermath, they experienced the series of terrifying events faced by all New Yorkers, including a plane crash in nearby Queens, the anthrax contamination, numerous threats of other terrorist attacks, heightened terrorist alerts, and the war in Afghanistan and Iraq.

Within these communities, one school of six hundred children, displaced from their school building on September 11, was offered a vacant school as a temporary measure. In one weekend, the parents came together, cleaned, painted and moved furniture into the school, making it usable for the children to attend the following week. The sense of togetherness that accompanied practical activities occurred numerous times during the year and was seen by many parents as one of their most important experiences for promoting a sense of normalcy and well being in their families.

When community members come together around practical concerns, they enhance their social connectedness, and, as we have recognized in New York City and in other places around the world that have been impacted by major trauma, these social contexts become the sites for sharing information about resources, conversation, problem solving, and mutual support.

***Case Example 2**: Buenos Aires Province, Argentina: "10,000 Lideres Para El Cambio"*
(10,000 Leaders for a Change)

The first author (JL) was invited to consult to the Ministry of Health and the Secretary of Prevention and Treatment of Substance Abuse and HIV/AIDS, Province of Buenos Aires, Argentina, following a period of severe political unrest and economic upheaval, with violence and disintegration of families with members who had been "disappeared," (kidnapped or killed). A wide-scale survey had found a significant increase in problems related to addiction and a concomitant rise in the sero-prevalence of HIV. The primary goal of the Ministry was to stem the tide of the increasing prevalence of addiction and HIV/AIDS. The survey showed that the majority of families in Buenos Aires Province (with an urban and rural population of 12 million) had been impacted by the problems.

Together we decided that the province-wide community-based program would focus on both prevention and intervention and would be designed for maximum penetration of the population. The first task was to train professionals and paraprofessionals in the LINC model, and how to conduct resilience-based community forums, aimed at prevention and intervention for the long term. The process of LINC Community Resilience is a continuum of assessment and intervention.

Pre- and post- program surveys were developed, covering, for example: demographics, attitudes toward, and use of, addictive substances, sexual attitudes, practices and risk, knowledge of, and attitudes toward, HIV/AIDS, family structure and function, closeness to family and culture of origin, and recent major events in family, community and larger context.

A series of maps was made to help determine how to divide the Province into logical segments for the intervention. The community forums were also designed to serve as focus groups in order to ensure true representation. They comprised a comprehensive cross-section of the population for age group, type of employment, social and economic standing, culture, gender and ethnicity. For example, at one of the meetings, participants held very different roles such as Ministers of Economy, Education, Health, and Social Welfare; teachers, doctors, and clergy; school cleaners and cooks; regional and local police; trash collectors and street sweepers. All participants completed the pre-program survey and family members from youngest to oldest took part in the proceedings.

Mapping as an Assessment Tool for Intervention

Mapping is a central process and takes us from assessment into intervention almost seamlessly. The maps we use include (Landau & Clements, 1993):

- *Transitional Maps*: Transitional Genogram (culture, geography, job, spirituality, religion); Number of Transitions and Time Line; Historical Maps and Stories; Family Life Cycle; Stories, Themes, Scripts (Byng-Hall, 1988), Strengths, Resources and Hierarchies;

- *Sociological Maps*: Transitional Field Map; Multisystemic Levels Map; Structural and Functional Pyramid; Sociogram/Ecogram; Contact Communication Map, and

- *Geographic Maps*

To illustrate the use of mapping in Case Examples 1 and 2, we have selected The Transitional Field Map (Landau & Clements, 1993) and the Multisystemic Levels Map (see figures 1 and 2 below) based on general systems theory (Saul, 2000). The Transitional Field Map was developed from field theory (Lewin, 1935), the depiction of the biopsychosocial system (Engel, 1980) and Transitional Family Theory (Landau, 1982; Landau-Stanton & Clements, 1993; Seaburn et al., 1995). It provides a multi-level, multi-systemic construct of the community that enables one to assess structure, function, organization and process at each level. One can determine the presence or absence of people and resources at each level and get a preliminary sense of how they interface with one another and the community as a whole. It is also crucial for community intervention to make a clear distinction between natural and artificial or ancillary support systems for the process of joining communities and coordinating their interventions. The map also shows how each level impacts the next, and how changes or problems anywhere in the system will reverberate throughout. Once the assessment is complete, the map shows the complexity and richness of the context, spanning the bio-psycho-social-conceptual-evolutionary ecosystem (Auerswald, 1983). It provides a template for designing interventions and guides decisions about who should be involved, and what the ultimate goals need to be.

<div align="center">Insert Figure 1 here</div>

Stories and history develop spontaneously during the further mapping process. Assessment includes resources and losses as well as key events and transitions across time. During the process of mapping, a major reframing occurs, as people gain an understanding of their transitional perspective, realizing that the events and sequelae that have occurred, as well as their own responses and those of their neighbors and community, were beyond anyone's control. They

gain an understanding that they have a wealth of resources and history to draw upon and that they do have the capacity to heal.

Case Example 1: The Lower Manhattan Communities after September 11, 2001

In the Lower Manhattan Community in the immediate aftermath of the terrorist attacks, rather than local resources being tapped in the community at a natural support system level, multiple individual professionals and numerous provider organizations from the ancillary or artificial support systems rushed in, diminishing the capacity of the community to design its own direction of healing. For example, funding was provided to screen children for mental health difficulties based on research indicating that parents' and teachers' assessments of children were unreliable. Yet the idea of educating parents and teachers on how to recognize and better respond to children's difficulties was rarely considered. Privileging the expertise of professionals undermined the confidence and resourcefulness of both teachers and parents (Saul, 2002a).

Community members who make up the natural support system have many advantages over outside providers in affecting change after a crisis. They have greater access to the local knowledge of existing resources and to vulnerable populations, and have networks of relationships that have developed over time. They are often already engaged in positive social processes that build community solidarity and cohesion, such as community association meetings and voluntary work. Because these efforts are driven by the community members' priorities and preferences, they are generally more successful than activities imported into the community by outsiders. Community members also have a greater investment in the development of their neighborhoods and are more likely to maintain activities long after the funding for an immediate crisis dries up or attention shifts to a new crisis elsewhere.

As part of the mapping and assessment of the natural and ancillary support systems, we need to remove the we/they dichotomy between the "professionals" and the people served. In times of community-wide trauma, the entire community, including the professionals within it, is impacted. An artificial division between those who "know and can do," versus those defined as "overwhelmed, and needing help," is counterproductive. During times of trauma we may shift from the one position to the other, and it is important for professionals to understand their own reactions to traumatic events to be able to contribute to the healing of a community.

insert Figure 2 here

Community resilience approaches are systemically focused and address multiple levels and themes in the process of recovery. A shortcoming of many trauma programs is that they address trauma primarily at the level of the individual, while ignoring the larger contexts. Both the Multisystemic Levels Map (fig. 2) and the Transitional Field Map (Fig. 1) are useful in planning intervention strategies that take into account the impact and resources at each level. The disruptions that affect family systems, work organizations, and communal structures are often the most debilitating because they may lead to community fragmentation, conflict, and destabilization.

Assessment of Impact of Past Trauma:

The loss of hope and positive vision is the root of transmission of negative intergenerational patterns that develop as a consequence of massive trauma, when multiple levels and too many people have been affected and are overwhelmed. As noted above, dysfunctional patterns are likely to develop from past attempts at adaptation and the impact is seen at a community level with such sequelae as addiction, depression, violence and post-traumatic stress disorder (PTSD). An understanding of the history of communities coping with disaster provides a very different perspective on these problems. For example, many political refugee communities have also experienced massive natural disaster and concomitant loss and hardship in their countries of origin. This past experience invariably plays a crucial role in how they interpret and deal with their current circumstances. Understanding this background is an essential component of establishing effective prevention and intervention programs.

Assessing Resilience in Operation

In order to assess the practical aspects of resilience we need to examine those factors that directly impact family and community process, structure, function and organization. For example, what resources are available within the families and within the community as a whole? If present, how are they being accessed and utilized? What is the level of stress and balance between stressors, stress levels and resources? Has connectedness and continuity of the transitional pathway been disrupted? Do the families and communities know their stories about past adversities and how they overcame them? Are the clusters of strengths and themes of resilience rather than vulnerability being mobilized in the struggle with hardship?

"People have many unexpected competencies and resources that may contribute to healing. Community members with diverse skills and ages contribute in different ways to the resilience of the community. The elderly bring memories of coping with previous tragedies, while children

may renew the capacity for play and spontaneity. People bring a diversity of strengths and skills based on occupation and talents – from artistic to organizational management skills, from the sublime to the mundane. Thus recovery can be seen as a creative process arising from the synergy of various community actors coming together to work toward a common purpose (Saul, 2004).

III. RESILIENCE-BASED COMMUNITY-WIDE INTERVENTION

As evident in Case 2, the process of assessment and intervention is a continuum.

Case Example 2: Buenos Aires Province, Argentina: "10,000 Lideres Para El Cambio"

During the community forums described above, representative members of the community, (sometimes as many as 5,000) developed their own concept of resilience, using such words as "trust, faith, confidence, hope, loyalty, spirituality, and survival." Following protocol guidelines, they divided into small discussion groups, each representing a cross-section of the community. Each group developed its overarching goals for the future. All were committed to the goals set by the ministry but also developed several of their own.

The groups then worked as collaborative teams to select their "community links" to bridge the ministry professionals and paraprofessionals with the community workgroup. They then identified workable tasks from their goals, and arranged work groups to achieve them. These tasks ranged from non-related elders providing after school care for children, to developing evening study groups with built-in babysitting for single parents, to collaborating with the police to rid a neighborhood of drug dealers, and establishing a formal organization, Padré a Padré to serve parents of children struggling with issues of substance abuse or addiction.

To keep the community informed of their progress, the ministry committed to daily brief bulletins in the national media on the results of the workgroups. Within a two-year period, there was a 200% increase in the admission to treatment of young people struggling with alcohol or drug abuse. In another major shift, the most were brought to, and supported in, their treatment by their family members.

1. Principles of the LINC Community Resilience Model

Some of the philosophy and principles of Transitional Family Therapy and the LINC Model are illustrated in the case examples above.

Principles

• Ensure that we have an invitation, authority, permission and commitment from the community

• Engage the entire system of the community, including representation of individuals and subsystems from each cultural and ethnic group, all economic, cultural and status strata

• Identify scripts, themes and patterns across generations and community history

• Maintain sensitivity to issues of culture, gender and spirituality

• Encourage access to all natural and ancillary resources (biopsychosocial, cultural, ecological)

• Build an effective prevention/management context by collaborating across all systems

• Foster a balance of agency and communion across the community

• Build on existing resources

• Relate program needs to goals, future directions and best interests of the community

• Utilize resources, turn goals into realistic tasks, and those into practical projects

• We provide the process, the community takes responsibility for the content and goals

• Encourage community links (natural change agents) to become leaders in their communities

• The more peripheral we are, the more successful are the program and the community

• Success of the project belongs to the community

In applying these guidelines to traumatized communities, we would like to highlight a few points. We need to find ways to empower families and communities to ensure that every effort is made to remove any sense of blame, shame and guilt experienced as a result of their hardship and losses. One of the first tasks is to help them identify their resources. The Transitional Field Map and Multisystemic Levels Map provide an easy template for this. The utility of resources varies with the type of trauma experienced. For example, after an earthquake, at the individual level, it might involve control of fear in order be able to find survival tools or move out of a potentially hazardous or life-threatening situation. In terms of social resources, it might mean finding any member of the family or natural support system and recreating the neighborhood, where people are relocated even temporarily, in proximity to old friends and neighbors. At the larger system level, it may mean recreating the rituals, routines and cultural environment of the community (Landau, 1982; Landau-Stanton, 1986; Landau, 2003).

Creativity is one of the most central resources in the process of healing (Saul, 1999). The impulse to create, to make objects, to symbolize, to rebuild what has been destroyed, to externalize memories of suffering so that they can be communicated to others and thus transformed is inherent to humanity's adaptive capability in times of destruction. Our psychotherapeutic work with children has shown us that the creative process is synonymous with

the process of healing. Children find ways of healing from painful and traumatic experiences through play and artistic expression. Adults are often constrained by their reliance on words. The language of the imagination can engage the entire person and all his/her capacities, crucial in the process of recovery. In addition, creative expression is the way of reconnecting the transitional pathway, its myths, stories, strengths, and resources across time.

One of the key factors is continuity of the family. When children are separated from their parents, the discontinuity impairs the healing of the community. This too often occurs when the multiple outside organizations come into a community to "help." They inadvertently reduce the community's effectiveness to take initiatives by ignoring the importance of the integrity and continuity of the family.

Other governing principles include identifying patterns and people across generations and across the history and current context of the community, including cultural and economic diversity. Since massive trauma usually results in major physical and medical sequelae, with untimely loss of life and resultant time compression and reversal of the family life cycle, we need to help families and communities work through unresolved transitions, particularly issues of grief and loss.

One of the most important processes for healing is the gathering of people, allowing them to reconnect, to gain a sense of mutual support and an understanding of the normality of their responses. They also need to share their stories of survival across time to reinforce their ideas of resilience and hope for the future. The rituals that keep communities alive across time are critical for re-establishing routine, and providing a format for constructive community action. In order to comprehend massive loss, one needs to understand how the group identity is shaped by its cultural beliefs about death and loss, and by their rituals and traditions for bereavement (Eisenbruch, 1991; see Chs. 7, 8, 9). For example, a group of nuns in El Salvador were called upon to help a community deal with the exhumation of bodies from mass graves. They worked with the community to revisit their cultural and spiritual beliefs and practices to develop a communal ritual for the process. The rituals developed by the community, helped by their local priests, brought together belief systems as varied as the Catholic faith and indigenous Mayan practices. The Catholic priests led the Catholic components while the Mayan indigenous healers led theirs (Ford and Searing, 2000)

In practical terms, members of the community need to establish a balance of agency and communion (McDaniel, Hepworth & Doherty, 1992) in order to be able to achieve co-operation.

17

Professionals need to be ready to delegate, refer and collaborate whenever necessary, rather than feeling that they're the only ones capable of providing support and wisdom.

2. Joining the Community

The principle that guides joining is that professionals should support natural support systems, rather than attempt to control or displace them. It is critical for professionals to ensure that they are invited as partners, rather than viewed as intrusive, and that they remain respectful and value the inherent competence of the community that they join. When the natural support system is functioning well, the ancillary support system works in an organized and efficient way as an adjunct to support the community process towards healing. Professionals move in the direction that the community chooses and interventions lead to the withdrawal of ancillary supports allowing and encouraging the community to take over. Actions are well coordinated and goal-oriented with very clear beginning and end points. When there is little or no encouragement of the natural support system, members of the ancillary support system tend to move in and replace family members and the natural support system. Instead, they can best foster recovery by providing an organized context within which the community can apply its own capacity to take charge of the direction of change.

It is all too easy for the ancillary support system to take over because, during times of trauma, local people's sense of competence and adequacy is often diminished by the overwhelming uncertainty and unfamiliarity of the situation. Or, they may feel that their previous competence is irrelevant and that they do not have the skills or wisdom to deal with the new realities. By recalling memories of the survival of their intergenerational families and their communities across time, people become aware that they do possess inherent strengths that they can pass on to generations to come. History reminds them that the competence and skills demonstrated by their forbears are still available to them now, in the midst of their own trauma and loss.

3. Family and Community Links (Link Therapists)

An integral component of the LINC model is working with natural change agents from their own communities, whom we refer to as Link Therapists or Family or Community Links. Their professional coaches are Link Facilitators, who have typically been trained (as we did in Argentina) in running community forums and guiding communities through the process. Community links allow us access to traditional extended families and communities, who would

normally, due to their culture and/or circumstances, not invite or welcome outsiders. They frequently seek help or care in a crisis and drop out as soon as the crisis is resolved.

The Community Links allow for effective collaboration, without outside professionals becoming embedded in their communities or intruding into their privacy. It leaves the ultimate decision-making to the people whose lives will be most impacted. We are responsible for facilitating their ability to tap into their own infrastructure for resilience. As systems-oriented professionals, we provide them with the process and techniques, and then we let them access their competence, so that projects in different communities are varied and are both culturally and contextually appropriate because what emerges belongs to them, not to us.

The Community Links are able to initiate and sustain the work, long after we, as outside professionals, have left. By targeting individuals, families and communities, they can develop a matrix of healing that bridges the entire community and endures over time.

Case Example 1: The Lower Manhattan Communities after September 11, 2001

A journalist who knew of second author Saul's work in trauma and journalism contacted him to meet with journalists who had been directly exposed to the events of September 11. He was interested in finding mental health professionals to support himself and his colleagues so we invited him to attend one of our community meetings. There he realized that, instead of developing a support group, he could contribute more as a Community Link. Recognizing their competence and capacity to heal, he and a fellow colleague initiated a peer support network of photo-journalists and reporters, which meets on a monthly basis and is drawing international attention (Lisberg, 2003).

4. BUILDING LONG-TERM COMMUNITY RESILIENCE: PREVENTION AND LASTING RECOVERY

1. Themes of Community Resilience

We have found that community resilience following massive psychosocial trauma usually encompasses the following four themes (Saul, 2002b):

o *Building community and enhancing social connectedness as a foundation for recovery.* Community recovery begins with the reweaving of social connections that have been disrupted by traumatic events. Referred to as the matrix of healing, we emphasize the reestablishment of old community connections while facilitating new ones (Landau, 1982; 2001; 2004). This includes strengthening the system of social support, coalition building, and information and resource sharing.

o *Collectively telling the story of the community's experience and response.* An important part of the communal healing process is having one's story validated and become a part of the collective story that emerges after a tragedy. This validation by the community is often described by those who survive major disasters as a crucial step in recovering their sense of well-being. As we have seen in New York City following September 11, the emerging story after such events needs to be broad enough to encompass the many varying stories experienced. It can be problematic when the dominant narrative is narrow, rigid or marginalizes segments of the population (Salvatici, 2001). As a glaring example of this, in Arabic-speaking and Moslem communities in New York and throughout the United States, many members have faced harassment, detention, and deportation purely as a result of their group identification. Invariably it is those people who do not have a voice whose story is excluded and who are further victimized after a collective tragedy.

o *Re-establishing the rhythms and routines of life and engaging in collective healing rituals.* Spontaneous neighborhood vigils, anniversary rituals, and community events marking seasonal changes and holidays are important for communities to reconnect with long established temporal rhythms, and to process the dissonant feelings associated with events of massive trauma. Many examples of this emerged following the traumatic events of September 11 (Fullilove, 2002; Fullilove & Saul, 2004; see Chapter 16).

o *Arriving at a positive vision of the future with renewed hope.* Many of the collective responses to September 11 were attempts to reestablish hope for the future. One of the most important questions faced by communities after a catastrophe is, "How do we move from haunting memories of the tragedy to a vision of the future that incorporates the new realities that we are facing?" The process by which a community develops a positive vision of its future is an important step in its recovery (Chemtob, 2002).

    2. Examples of Community Resilience after Trauma

    Each community resilience project described below illustrates one or more of these themes. The projects chosen reflect the particular needs of each community, where they are in the recovery process, whether they anticipate or fear another major traumatic event, and how they perceive their capacity to heal.

Case Example 1: The Lower Manhattan Community after September 11, 2001

    In the Lower Manhattan school communities after September 11, attention focused on potential pathology in children, and there was little place for parents to discuss their

concerns. In January 2002, with the plan to return the children to their home schools by the end of the month, many parents were feeling distress about going back for the first time to the place where, four months earlier, they had experienced the horror. Parents, teachers, school psychologists, and staff established family support groups that made connections across school communities, enabling the sharing of ideas about how to address the emotional issues of both children and adults.

These support groups later developed into a series of community forums, (similar to those described in the Argentina example), led by Chemtob, expanding the notion of healing beyond a primary focus on individual stress reactions to a broader notion of community-wide recovery. In this context, their many varied reactions could be normalized and a framework presented of the stages through which a community might pass following a disaster.

(1) "United we Stand:" In an initial stage, people experienced shock and then came together, sharing and letting their guard down; (2) "Molasses and Minefields:" As people started to get tired and irritable, stresses accumulated, tempers flared, people retreated into groups where they felt safer. During this stage, it was important to demonstrate that there were ways to reduce stress and tensions in the community; and (3) "A Positive Vision of Recovery:" In this stage, the community came together to build hope for the future, gaining an understanding that recovery is not a passive process, but a consequence of actively coming together for a common purpose.

During each meeting the group broke up into small groups according to the age level of their children, to discuss their concerns and ways to increase their skills as parents and teachers in order to best help the children. This included a collective conversation about how parents and teachers could take care of themselves and support each other as well. During this process, we noticed that there was a subtle modulation at a collective level. When people behaved in a markedly distressed manner, appearing to overestimate present and future danger, they received constructive feedback, helping them to become more realistic in their threat assessment. Similarly, when people became overly irritable, they could be reminded of the need to modulate their reactions. In this way, the community connectedness provided a matrix of healing and support along with sound reality testing. Even when this modulation was provided in a straightforward, and at times brutally honest

way, it was accepted with grace because of a sense of support and connectedness. A videotape of the forums was made for distribution to parents (Saul & Ray, 2002).

A community-needs assessment was conducted with the hundred participants of the community forum, and from this the Downtown Community Resource Center for Lower Manhattan was developed (see www.communityresilience.org/nyc). The primary goal was to provide a public space where community members could come together and share ideas, projects, resources, and their combined creativity. Through the Center, the Community Links were able to engage community members to develop a number of active projects, all of which are still functioning (in late 2003). These include: a video narrative archive; a theater of witness project; various art projects; a community-based disaster preparedness and response initiative that has produced; a published manual; a community website; a computer education program for senior citizens; peer support programs, including one for artists and the journalist group mentioned above; and a Samba school.

Case Example 2: *Buenos Aires Province, Argentina: "10,000 Lideres Para El Cambio"*

Some of the activities and groups that developed in different communities in Buenos Aires Province included: A partnership of police, school personnel, parents, and community residents to expel drug dealers from the neighborhood; the Padré a Padré group, which grew into a nationwide initiative which continues to meet; a program for evening education for literacy, business skills, and handcrafts; and a social group for children and families of the military to become integrated into the communities in where they are stationed.

Other examples from different contexts include discussion groups around the trauma of floods and earthquakes in Taiwan; a nationwide prevention and intervention program for addiction, violence and HIV/AIDS in Hungary; and, in the Liberian refugee community in New York City, a transgenerational oral history project, a task force on youth education, a rap group, and a computer education program for teenagers.

CONCLUSION

By tapping the inherent resilience of communities, professionals can best foster their healing from devastating widespread trauma and loss. Multi-systemic approaches can capitalize effectively on the richness of individual, family, and community resources that are the critical components of this healing. Our conceptual framework and experience underscore that it is vitally important to identify these resources and work with community members as Community

Links to create a matrix of healing throughout the community. This approach can be highly effective in ensuring long-term viability and hope for the future.

REFERENCES

Antonovsky, A. *Health, stress and coping*. San Francisco: Jossey-Bass.

Auerswald, E. H. (1983). The Gouverneur Health Services Program: An experiment in ecosystemic community care delivery. *Family Systems Medicine*, *1*(3), 5-24.

Bell, C. C. (2001). Cultivating resiliency in youth. *Journal of Adolescent Health*, *29*(5), 375-381.

Bentovim, A. (1995). *Trauma organized systems*. London: Karnac.

Boss, P. (1999). *Ambiguous loss*. Cambridge, MA: Harvard University Press.

Boss, P. (2001). *Family stress management: A contextual approach*. Thousand Oaks, CA: Sage.

Boss, P., Beaulieu, L., Wieling, E., Turner, W., & LaCruz, S. (2003). Healing loss, ambiguity, and trauma: A community-based intervention with families of union workers missing after the 9/11 attack in New York City. *Journal of Marital and Family Therapy, 29*(4), 455-467.

Bowlby, J., (1969). *Attachment and loss: Vol. 3 Loss. Sadness and depression*. London and New York: Hogarth.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London: Routhledge.

Byng-Hall, J., (1988) Scripts and legends in family therapy. *Family process*, *27*(2), 167-180.

Calhoun, L.G., & Tedeschi, R.G. (1999). *Facilitating post-traumatic growth: A clinician's guide*. New York: Lawrence Erlbaum, Assoc.

Carter, B., & McGoldrick, M. (1999). *The expanded family life cycle: Individual, family, and social perspectives*. (3rd. ed.). Boston: Allen & Bacon.

CASA. (2003). Survey of 1,000 American teens ages 12-17 released Wednesday, February 21, 2001 by The National Center on Addiction and Substance Abuse at Columbia University.

Chemtob, C.M., & Taylor, T.L. (2002). The treatment of traumatized children. In Yehuda, R. (Ed.) *Trauma survivors: Bridging the gap between intervention research and practice*. American Psychiatric Press, Washington, D.C.

Chemtob, C. M. (2002, November) A public health approach to trauma recovery. A paper presented at a workshop of the International Trauma Studies Program, New York University, New York.

Clark, C. R., McFarlane, A. C., Morris, P., Weber, D. L., Sonkkilla, C., Shaw, M., Marcina, J., Tochon-Danguy, H. J., & Egan, G. F. (2003). Cerebral function in posttraumatic stress disorder during verbal working memory updating: a positron emission tomography study. *Biological Psychiatry, 53*(6), 474-81.

Danieli, Y. (1981). Differing adaptational styles in families of survivors of the Nazi Holocaust: Some implications for treatment. *Children Today*, *10*(5).

Danieli, Y. (1985). The treatment and prevention of long-term effects and intergenerational transmission of victimization: A lesson from Holocaust Survivors and their children. In C.R. Figley (Ed.) *Trauma and its wake*. (pp.295-313). New York: Brunner/Mazel.

Durkheim, E. (1897). *Suicide: A study in sociology.* London: Free Press.

Eisenbruch, M. (1991). From post-traumatic stress disorder to cultural bereavement: Diagnosis of southeast Asian refugees, *Social Sciences & Medicine*. *33*, 673-680.

Engel, G. L. (1980). The clinical application of the bio-psychosocial model. *American Journal of Psychiatry*. *13*(5), 535-543.

Figley, C. R., & McCubbin, H. I. (Eds.) (1983). *Stress and the family, Volume II: Coping with catastrophe*. New York: Brunner/Mazel.

Figley, C. R. (Ed.). (1996). (Ed.). *Death and trauma*. London: Taylor and Francis.

Figley, C. R., & McCubbin, H. I. (Eds.) (1983). *Stress and the family, volume I: Coping with normative transitions*. New York: Brunner/Mazel.

Ford, B., & Searing, V. (2000, April). Community approaches: Mayan survivors in Guatemala. Paper presented at the International Trauma Studies Program, New York University.

Fullilove, M. (2002, April). Together we heal: Community mobilization for trauma recovery. Paper presented at a meeting of Columbia University School of Public Health. New York.

Fullilove, M., & Saul, J. (2004). Community psychiatry in the wake of Sept.11 in New York City. In Y. Neria, R, Gross, R. Marshall, R., E. Susser (Eds.), *September 11, 2001: Treatment, research and public mental health in the wake of a terrorist attack* (pp.). Cambridge: Cambridge University Press.

Garbarino, J., & Kostelny, K. (1996). What do we need to know to understand children in war and community violence? In R. J. Apfel & B. Simon (Eds.), *Minefields in their hearts: The*

mental health of children in war and communal violence (pp. 33-51). New Haven: Yale University.

Garbarino, J. (1992). *Children and families in the social environment* (2nd ed.) New York: Aldine de Gruyter.

Garmezy, N., & Rutter, M. (1983). *Stress, coping and development in children.* New York and London: McGraw-Hill.

Gavin, L. A., Wamboldt, M. Z., Sorokin, N., Levy, S., & Wamboldt, F. S. (1999). Treatment alliance and its association with family functioning, adherence, and medical outcome in adolescents with severe, chronic asthma. *Journal of Pediatric Psychology*; *24*(4): 355-65.

Grotevant, M. D., & Cooper, C. R. (1998). Individuality and connectedness in adolescent development: Review and prospects for research on identity, relationships, and context. In E. Skoe & A. von der Lippe (Eds.), *Personality development in adolescence: A cross national and life span perspective* (pp. 3-37). London: Routledge.

Haley, J. (1980). *Leaving home: The therapy of disturbed young people*. New York: McGraw Hill.

Hobfoll, S. E. (1988). *The ecology of stress*. New York: Hemisphere.

Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist, 44*, 513-524.

Horwitz, S. H. (1996). Trauma due to unresolved grief and its effect on the family. In C. Figley (Ed.), *Death and trauma* (pp.). London: Taylor and Francis.

Horwitz, S. H. (1997). Treating families with traumatic loss: transitional family therapy. In C. Figley, B. Bride, & N. Mazza (Eds.), *Death and trauma: The traumatology of grieving* (pp.). London: Taylor & Francis.

Horwitz, S. H., (2001). Grief and cultural transition: A journey out of despair. In S. H. McDaniel, D. Lusterman, & C. L. Philpot (Eds.), *A casebook for integrating family therapy* (pp.). Washington, DC: American Psychological Association.

Igra, V. & Irwin, C. E., Jr. (1996). Theories of adolescent risk taking behavior. In R. J. DiClemente, W. B. Hansen, & L.E. Ponton (Eds.), *Handbook of adolescent health risk behavior* (pp.). New York: Plenum Press.

Klingman, A., & Cohen, E. (2004). *School-based multi-systemic interventions for mass trauma*. New York: Kluwer Academic/ Plenum Publishers.

Landau, J. (1982). Therapy with families in cultural transition. In M. McGoldrick, J. K. Pearce, & J. Giordano (Eds.), *Ethnicity and family therapy* (pp.). New York: Guilford Press.

Landau, J. (1991, October). Community mobilization in the intervention and prevention of AIDS and drug abuse. Paper presented at the meeting of ASIBA and Pan South American Family Therapy Conference. Buenos Aires, Argentina**.**

Landau, J. (1997). Whispers of illness: Secrecy versus trust. In S. H. McDaniel, J. Hepworth, & W. Doherty (Eds.), *Stories in medical family therapy* (pp.). New York: Basic Books.

Landau, J. (2001, November) Enhancing family and community resilience in the face of trauma: community outreach and organization. Presentation at the International Conference of the International Family Therapy Association. Brazil, Nov. 2001.

Landau, J. (2003). Enhancing resilience: Families and communities as agents for change. Manuscript submitted for publication.

Landau, J., Cole, R., Clements, C. D., & Tuttle, J. (1995). Link individual family empowerment (LIFE): A method for facilitating family resilience through re-storying the Transitional Pathway. Unpublished manuscript**.**

Landau, J., Cole, R., Tuttle, J., Clements, C.D., & Stanton, M.D. (2000). Family connectedness and women's sexual risk behaviors: Implications for the prevention/intervention of STD/HIV infection. *Family Process, 39*(4), 461-475.

Landau, J., Garrett, J., Shea, R., Stanton, M. D., Baciewicz, G., & Brinkman-Sull, D. (2000). Strength in numbers: Using family links to overcome resistance to addiction treatment. *American Journal of Drug and Alcohol Abuse, 26*(3), 379-398.

Landau, J., Griffiths, J. A., and Mason, J. (1981). The extended family in transition. *Psychotherapeia, October, 7*(4).

Landau, J., & Stanton, M. D. (2003). A model for alcoholism and addiction within the family: I. Intergenerational genesis and the "When did It start?" question. Manuscript submitted for publication.

Landau-Stanton, J. (1986). Competence, impermanence, and transitional mapping: A model for systems consultation. In L. C. Wynne, S. McDaniel, & T. Weber (Eds.), *Systems consultations-- A new perspective for family therapy* (pp. 253). New York: Guilford Press.

Landau-Stanton, J. (1990). Issues and methods of treatment for families in cultural transition. In M. P. Mirkin (Ed.), *The social and political contexts of family therapy* (pp.). Massachussets: Allyn and Bacon.

Landau-Stanton, J., & Clements, C. (1993). *AIDS, health and mental health: A primary sourcebook.* New York: Brunner/Mazel, Inc.

Lee, M. B. (2002). Personal communication. Taipei, Taiwan.

Lewin, K. (1935). *A dynamic theory of personality: Selected papers by Kurt Lewin.* Translated by Donald K. Adams and Karl E. Zener, 1st edition. New York and London: McGraw-Hill.

Lisberg, A. (2003). 9-11 Journalists share memories, support. Retrieved September 24, 2003, from the University of Washington, Dart Center for Trauma and Journalism Web site: http://www.dartcenter.org/articles/oped/2003_07_11.html

Norris, F., Friedman, M., Watson, P., Byrne, C., Diaz, E., & Kaniasty, K. (2002). 60,000 Disaster victims speaks: Part I. An empirical review of the empirical literature, 1981-2001. *Psychiatry*, *65* (3), ?.

Padgett, D. (2002). Social work research on disasters in the aftermath of the September 11 tragedy: Reflections from New York City. *Social Work Research, 23*, 42-53.

Perel, E., & Saul, J. (1989). A family therapy approach to Holocaust survivor families. In P. Marcus, & A. Rosenberg (Eds.), *Healing their wounds: Psychotherapy with Holocaust survivors and their families*. New York: Praeger.

Salvatici, S. (2001). Memory telling. Individual and collective identities in post-war Kosovo: The archives of memory. *Psychosocial Notebook*. International Organization for Migration: *2*.

Saul, J. (1999). Working with survivors of torture and political violence in New York City. *Zeitschrift fur Politische Psychologie, 7(1-2),* 221 - 232.

Saul, J. (2000). Mapping trauma: a multi-systemic approach. *Psychosocial Notebook*. International Organization for Migration. November.

Saul, J. (2002a) Learning from humanitarian crises: Community recovery in Manhattan, post 9/11. Presentation at the International Society for Traumatic Stress Studies Annual Meeting, Baltimore, MD. November

Saul, J. (2002b, Sept. 11). 2 pillars are crucial to helping children adjust, *New York Times*. p. 17.

Saul, J. (2004). Promoting community recovery in downtown Manhattan. *BRIIFS: Bulletin of the Royal Institute for Interfaith Studies*.

Saul, J. (Producer), and Ray, J (Director). (2002) *A partnership for kids: post 9/11 coping strategies for the school community*. [Video] New York: International Trauma Studies Program, New York University

Saul, J., Ukshini, S., Blyta, A., & Statovci, S. (2003). Strengths based treatment of trauma in the aging: An Albanian Kosovar case study. In J. Ronch, & J. Goldfield (Eds.), *Mental wellness in aging: Strength based approaches* (pp.). London: Health Professions Press.

Seaburn, D., Landau-Stanton, J., & Horwitz, S (1995). Core intervention techniques in family therapy process. In R. H. Mikesell, D. D. Lusterman, & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp.). Washington, DC: American Psychological Association.

Sheinberg, M., & Fraenkel, P. (2000). *The relational trauma of incest: A family-based approach to treatment*. New York: Guilford Press.

Stanton, M. D., & Landau, J. (2003). A model for alcoholism and addiction within the family: II. Intergenerational Transmission, maintenance of symptoms, and the therapeutic implications. Manuscript submitted for publication.

Stinnett, N., & DeFrain, J. (1985). *Secrets of strong families*. Boston: Little, Brown.

Suddaby, K., & Landau, J. (1998) Positive and negative timelines: A technique for restorying. *Family Process, 37(3)*, 287-298

Tuttle, J., Landau, J., Stanton, M. D., King, K., & Frodi, A. (In Press, 2004). Intergenerational family relations and sexual risk behavior in young women. *The American Journal of Maternal Child Nursing.*

Walsh, F. (1998). *Strengthening family resilience.* New York: Guilford Press

Walsh, F. (2003). Family resilience: A framework for clinical practice. *Family Process, 42(1),* 1-18.

Watson, W., & McDaniel, S. (1998) Assessment in transitional family therapy: the importance of context. In J. W. Barron (Ed.), *Making diagnosis meaningful: Enhancing evaluation and treatment of psychological disorders* (pp.). Washington DC: American Psychological Association.

Weine, S. (1999). *When history is a nightmare*. New Brunswick, NJ: Rutgers University Press.