Chapter 6
Collective Trauma, Collective Healing

Trauma associated with forced displacement has a psychosocial impact not only on the individual, but also families, communities and larger society. At the family level, this includes the dynamics of single parent families, lack of trust among members, and changes in significant relationships and child-rearing practice. Communities tend to be more dependent, passive, silent, without leadership, mistrustful and suspicious. Additional adverse effects noted in the literature include the breakdown of traditional structures, institutions and familiar ways of life, and deterioration in social norms, ethics and loss of social capital (Somasundaram, 2014). Saul's (2013) landmark definition of collective trauma highlights its larger social impact, occurring at multiple levels, with "shared injuries to a population's social, cultural, and physical ecologies" (p. 1). In another seminal work on collective trauma, Erikson (1976) defines it as "a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality." (p. 154).

Considering experiences of trauma solely on an individual level, and solely related to an isolated event, is not enough. One needs to consider the impact of collective trauma—and recovery—among refugee populations from a sociocultural and historic perspective. Entire communities may have undergone traumatic experiences, and at various moments across history, disrupting core attachments to families, friends and cultural systems (Lindert et al., 2016). The literature suggests that the consequences of trauma exposure in a population of refugees may go beyond individual suffering to impacting family members and entire communities due to impaired psycho-social functioning in everyday life (Ainamani et al., 2017; Womersley & Arikut-Treece, 2019).

Over the past few decades, a plethora of research has highlighted the importance of the sociocultural environment for the way in which individuals, and indeed entire communities, experience trauma (Bracken et al., 1997; Eagle & Kaminer, 2013; Nickerson et al., 2016; Wilson & Drožđek, 2007). As stated by Jenkins (1996)

G. Theisen-Womersley, *Trauma and Resilience Among Displaced Populations*,
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> Because traumatic experience can also be conceptualized collectively, person-centred accounts alone are insufficient to an understanding of traumatic reactions. In addition to the social and psycho-cultural dynamics surrounding any traumatic response, the collective nature of trauma may be related to ... the political ethos characterizing an entire society (p. 177).

Eagle (2014) refers to notions of collective or historical traumatizations whereby whole groups of people carry a sense of common persecution or victimization:

> The idea of historical trauma is associated most strongly with the history of first nation people in America and the genocidal violence to which they were subjected. Collective trauma is the term that tends to be used about the response of groups of South Africans subject to a brutal apartheid and colonial history, as well as about the response of groups of Jewish people to the Holocaust. Such trauma may be understood to be transmitted intergenerationally via both conscious and unconscious mechanisms, such that those of generations post those directly victimized nevertheless carry the experience of trauma within themselves. In some respect identity and collective trauma come to be intertwined. Such conceptualizations of trauma may encompass a somewhat broader definition of traumatic stressors including not only relations of oppression that threaten actual survival of the group, but also more ideological forces that threaten the eradication of cultural or group identity. In this framework racism, xenophobia or fundamentalisms based on oppression may be understood to produce collective traumatisation. (p. 13)

She suggests that people may be traumatized at multiple levels. This includes collective/social, personal/physical and role identity levels. This point is no more pertinent to bear in mind than in the case of refugee populations often faced with a plethora of traumatic events on a collective level. Becker's (1995, 2004; Becker et al., 1990) concept of extreme trauma further encapsulates the extremity of such collective and historic trauma, defined as the following:

> Extreme traumatisation is an individual and collective process that refers to and is dependent on a given social context; a process that is marked by its intensity, its extremely long duration and the interdependency between the social and the psychological dimensions. It exceeds the capacity of the individual and of social structures to respond adequately to this process. Its aim is the destruction of the individual, of his sense of belonging to society and of his social activities. Extreme traumatisation is characterized by a structure of power within the society that is based on the elimination of some of its members by other members of the same society. The process of extreme traumatisation is not limited in time and develops sequentially. (Becker, 2004, p. 5).

Considering trauma thus as a process, elements of temporality are highlighted, as is the continual interaction of the person with their environment in a given social and historical context. What is particularly interesting in this definition is the highlighting of the socio-political context and power dynamics at play in influencing the mental health of whole populations. Considering the "elimination of some of its members by other members of the same society" referred to in the definition is pertinent both to situations of conflict as well as to societal dynamics at play for refugee communities attempting to integrate into host societies and facing possible discrimination. Following prolonged or repetitive traumatisation, entire communities may thus

develop a complex constellation of shared feelings, attitudes and behavioural patterns deeply informed by post-traumatic responses and which may force groups into the role of victim—passive, unskilled, unable and unsure (Makhashvili & Tsiskarishvili, 2007).

Loss of "Home" as Container

Among a sample of Iraqi asylum seekers in the Netherlands, 87.6% reported experiencing the loss of a loved one, with traumatic and multiple losses independently predicting psychopathology (Hengst et al., 2018). Yet, even among those refugees who have not directly experienced the loss of a loved one, loss is an inevitable component of the migration experience. As noted by Du and Witmer (2020), loss associated with the refugee experience is not only that of loved ones as well as the geographical home (often representing a loss of decades, if not centuries, of investment), but also of the familiar sociocultural context (which they refer to as the "psychosocial milieu") as well as a disruption of the life biography (which they define as "a unique web of situated life episodes" [p. 38]) at the level of the individual, the community, and the generations that lived in a certain place at a certain time.

Volkram (2004) argues that "since moving from one country to another involves loss—loss of country, friends and of previous identity—all dislocation experiences can be examined in terms of the immigrant's ability to mourn and/or resist the mourning process." (p. 8). The seemingly paradoxical nuance referred to within this literature is that not all refugees suffer from PTSD on an individual level, yet that pre-migration experiences necessarily involve loss at the communal level which in itself is potentially traumatic. In other words, in order to reflect on the traumatic experiences of refugees, one cannot neglect to examine what has been necessarily been lost to entire communities before embarking on the journey of migration. Rousseau et al. (2014) note the impact of the cumulative effects of a grieving process for communal losses and separations related to forced migration, referring to what Eisenbruch (1991) terms "cultural bereavement." A multi-level path analysis conducted by Nickerson and colleagues (Nickerson et al., 2011) similarly demonstrates how loss and trauma significantly impacted on psychological outcomes among refugee families as a whole in a way that extends beyond individual mental health.

Papadopoulos (2002a, 2002b, 2007) draws on the notion of "nostalgic disorientation" to refer to the uniqueness of this bewildering predicament:

> The loss is not only about a concrete object or condition but it encapsulates the totality of all dimensions of home…. Refugees sense the impact of this multidimensional, deep and pervasive loss and they feel disorientated because it is difficult to pinpoint the clear source and precise nature of this loss…Whenever the home is lost, all the organizing and containing functions break wide open, and there is the possibility of disintegration at all of these three levels: at the individual-personal level; at the family-marital; and at the socio-economic/cultural-political level (Papadopoulos, 2002a, p. 15, p.24).

His main argument is that the loss of home is not just about the conscious loss of the family home with all its material, sentimental and psychological values, but it is a loss of a much more fundamental and symbolic kind which necessarily creates a psychological disturbance.

An important characteristic of home, which inevitably is lost to some extend in the process of migration, is that it grounds and provides coherence to the stories of families. Each family has a story which, its own story which does not necessarily coincide with an external historical account of it. Like all stories, it consists of many more smaller stories of specific facets of the family. As such, "family stories express the interconnection between the personal, family and wider parameters within the context of a sense of home that enables the holding and containing of all opposite and contradictory elements that threaten to disrupt the sense of continuity and predictability" (Papadopoulos, 2002a, p. 25). As Masade (2007) notes 'home embodied objects, languages, practices (which evolved into traditions), histories, myths and faiths [are] all bound to a specific location' (p. 94) which is lost in the process of migration. This loss necessarily contributes towards a sense of empowerment, identity and meaning in life being compromised on a community level (Drožđek & Wilson, 2007; Schweitzer et al., 2006). Falicov (2002) similarly reflects on the loss and resilience inherent to the family migration experience, noting that what refugees have in common is the painful loss of home and separations from loved ones and the inevitable mixed emotion of sadness for what they have lost as well as the elation for what they could gain, the ambivalence of wanting to stay and wanting to go.

Collective Responses to Trauma

Not only may traumatic events be experienced collectively, the psychological impact and manifestation of such trauma is similarly thought to be informed by the sociocultural context. The burgeoning field of cultural psychiatry highlights how cultural variations in ways of life and social contexts shape the embodied experience of trauma and recovery (Kirmayer & Ramstead, 2016). This research demonstrates how particular symptoms or behavioural expressions of distress vary with cultural knowledge, beliefs and interpretations (Kleinman, 1978) and that individuals interpret and respond to their own symptoms with culturally varied coping strategies that may influence the experience of trauma and recovery (Ryder et al., 2011). The work of Kirmayer and colleagues (Kirmayer, 2019; Kirmayer & Jarvis, 2019; Kirmayer & Minas, 2000) for example, demonstrates how the experience of trauma is always preceded by and embedded in cultural systems of meanings and practices, which influence modes of attention and interpretive frames or models. Cultural models may be organised in many ways, including collective symbols, images or representations and forms of cooperative activity. In other words, experience of trauma is an

intersubjective, temporal, dynamic process shaped by culture. This approach goes beyond a reductionist focus on "cultural differences," wherein "culture" is perceived a reified, crystallised concept and viewed as a potential barrier to be overcome in a process of psychiatric classification (Watters, 2001). Instead, it focuses on ever-changing cultural and social systems, which determine the various forms in which trauma manifests on a collective level.

Collective, Culturally-Based Interventions

The under-utilisation and mistrust of mainstream mental health services by ethnic minorities in general—and displaced populations in particular—has been well documented (Bigfoot & Schmidt, 2010; Mattar, 2011; Watters, 2001). In the literature, this mistrust been attributed in part due to the variations in culturally informed healing practices and perceptions of mental health services. Indeed, contemporary health related approaches have a western medical illness model perspective that is primarily individualistic in orientation, in contrast to more collectivist ways of understanding relationships between self, society, mind, and body (Somasundaram, 2014). Research conducted among displaced populations by Karageorge et al. (2016) identified the following barriers to the acceptability and validity of mental health services among displaced populations in Greece:

(1) Mistrust or uncertainty of intentions/expectations,
(2) Having more immediate (practical) concerns than talk,
(3) Difficulty discussing trauma and
(4) The inadequate cultural competence of health professionals.

A recent desk review released by the World Health Organization (WHO) and the United Nations High Commissioner for Refugees (UNHCR), the United Nations Refugee Agency, has argued that the development of effective MHPSS programmes requires knowledge of existing health systems and sociocultural context, and that familiarising international humanitarian practitioners with local culture and contextualising programmes is essential to minimise risk of harm, maximise benefit and optimise efficient use of resources (Greene et al., 2017). Developments in theories of identity, culture and traumatology have enriched cross-cultural understanding of mental health dynamics and case conceptualisation, informing the development of intervention models which aim to address cumulative trauma dynamics as well collective identity and culture-specific traumas (Groen et al., 2017; Kira, 2010). As noted by Wind & Komproe (2018), researchers and practitioners have called for interventions which incorporate the socioecological perspective into their design. Their research reveals the links between the individual process that determines disaster

mental health and the social community one lives in—highlighting the necessity of interventions to consider the shared context on mental health outcomes.

For communities affected by genocide in particular, literature from Rwanda (Pearlman, 2013; Kanyangar et al., 2007; King, 2011; Staub et al., 2005), Guatemala (Marín Beristain et al., 2000) and Bosnia (Ba & LeFrangois, 2011; Clark, 2008; Denborough, 2011) all highlight the profound impact of public rituals of mourning and remembrance in healing from collective and historic trauma. In Rwanda, this involved engaging in Gacaga tribunals (Kanyangara et al., 2007; King, 2011), and in Guatemala, this involved collective sharing, commemorative activities and funeral rites for the Mayas—including symbolically identifying and punishing those responsible (Marín Beristain et al., 2000). In Bosnia, collective healing was shown to revolve around the principles of the "three Rs"—retributive justice, restorative justice and reconciliation, as mediated for example by the International Criminal Tribunal for the former Yugoslavia (Clark, 2008).

One striking example of collective healing may be drawn from my experience of working with the displaced Yezidi population of Northern Iraq: when the highly traumatised girls and women returned from Islamic State (ISIS) captivity, the spiritual leader of the community welcomed them back. The symbolic gesture was intended to lift the shame, which so often accompanies survivors of trauma (Maercker & Horn, 2013). This precious act seems to have enabled the women to be accepted back within the community. Some of the released hostages performed a purifying ceremony at Lalish, considered the holiest temple of the Yezidi faith. These healing interventions were enacted on a collective level—drawing on cultural and symbolic resources known to the community. One could argue that without these interventions, the released hostages would risk further traumatisation because of subsequent guilt, shame and social stigma: the rupture with the community is in itself traumatic. Within this context, individual trauma-focused therapy as typically prescribed within a Western model would be simply insufficient at best, harmful at worst.

To explore the collective impact of trauma on entire displaced communities, this chapter will draw on two case studies from my work in Iraq and the Philippines, first introduced in chap. 3: the forcibly displaced Yezidi community of Kurdistan Northern Iraq, (200 women whom I interviewed in the context of a project evaluation—where PTSD prevalence was an estimated 82%), and displaced communities affected by the recent conflict in Marawi, Philippines (factors of collective trauma and recovery explored by myself and colleagues among 80 participants in the context of a mental health needs assessment, where PTSD prevalence was an estimated 78%).

Case Study One: The Displaced Yezidi Community of Northern Iraq

This case is first introduced in chap. 3—where the staggering estimate of PTSD prevalence among the Yezidi community is shown to be 82%. In this chapter, I explore the

impact of this collective trauma at multiple levels: collective/social, personal/physical and role identity. I also explore the substantial impact of the political, legal, and socio-cultural environment on these experiences of collective trauma and recovery. The case study also appears in an article published in *Intervention* entitled "Collective trauma among displaced populations in Northern Iraq: A case study evaluating the therapeutic interventions of the Free Yezidi Foundation" (Womersley & Arikut-Treece, 2019).

According to Mohammadi (2016), the Yezidi community in particular is facing "not just the individual recent trauma related to the 2014 attacks, but a historical trauma too—they faced genocide 73 times during the Ottoman Empire" (p. 410). This research highlights both the historic and collective nature of the trauma to which the Yezidi population has been exposed, related to historic and ongoing oppression and exposure to violence, as well as identity-related trauma among displaced populations attempting to integrate into host communities (Gerdau et al., 2017; Groen et al., 2017). It is not only individuals facing traumatic events but entire communities.

Among the Yezidi community, Ceri et al., (2016) note a variety of culturally informed idioms of distress drawn on by Yezidis to express their emotional distress:

> The term "Ferman" is an expression for destruction and holocaust and reminds them of massacres against Yazidis; it means at once genocide and trauma. Every Yazidi knows the word "Ferman" because the term passes on from one generation to the next. In the context of the terror attacks by ISIS, the term "Ferman" regained a massive impact for Yazidis. It evokes feelings of mourning and fright. Two further idioms of distress are "nefsî" (arab. psyche), which is used synonymously for all mental disorders and traumas, and "liver burned" (cigera min shewiti), which means emotional suffering (p.146).

The trauma is transmitted inter-generationally. It is experienced collectively, within a particular cultural context. If we're not localising trauma on an individual but rather a community level, what are the practical implications for mental health interventions? What is being done efficiently and what needs to change? How can interventions consider the underlying sources of collective trauma in a way which reflects "local histories and systemic issues of politics, identity and community" (Kirmayer et al., 2010, p. 14)? How can we facilitate collective healing? To explore this question, I conducted 16 focus group discussions (FGDs) with Yezidi women attending the Free Yezidi Foundation, and six in-depth interviews with members of the project team.

Direct quotes from transcripts of these interviews and FGD are presented under the following identified themes:

- Impact of events
- Manifestations of trauma
- Collective trauma
- Culturally informed idioms of distress
- Perceptions of mental health services

The Impact of Events

The Yezidi community's experiences are characterised by a context of complex trauma. Trauma was related to not only exposure to human rights violations and other atrocities in 2014, but compounded variables related to.

- Multiple losses (home, family members, possessions, socioeconomic status)
- Fear of ongoing attacks
- Breakdown of the family unit (due to loss, separation and family members seeking refuge abroad)
- Poverty
- Gender roles being threatened due to men losing employment opportunities
- Poor living conditions in the camps (including cramped living quarters)
- Feeling "trapped" in the camps
- Uncertain futures
- Ethnic discrimination

The following quotes highlight some ways in which members of the Yezidi community described their current situation:

> Years are lost from our lives
>
> In general, we are still, we're just as scared about the future and what will happen, so it's all in our mind. They're saying that the same thing will happen again because they say 'you are a minority' and usually there is no one, for example, to protect you.
>
> The trauma is bigger than the time with ISIS, because, maybe you are not—you just want to be at home, not going alone, you just don't want to see a friend. It's like from social person to person who is avoiding everything. In each way. Like the day is one trauma, during ISIS it's trauma, after ISIS also it's trauma and it's been like four years, we've been here in the tents, it's a big trauma here, obviously.

For the Yezidi community, the trauma is "bigger than the time with ISIS." In other words, the trauma is not related to a specific single, isolated (or isolatable) event. It extends beyond the news headlines. It extends beyond the borders of time. It is both related to the past, to generations of oppression, conflict, and violence; as much as it is related to the future, a future which makes them "just as scared." It impacts social relationships within the community ("you don't want to see a friend"). It's exacerbated by appalling current living conditions in the camp. The trauma of displacement pervades the community—leading to a generation who have "lost years" of their lives. As one woman noted,

> We are thinking about the past and the future at the same time

Manifestations of Trauma

Nightmares and insomnia were the most common symptoms reported in the FGD. Many reported feeling scared, jumpy or alert—particularly at night. Increased aggression was also noted—with augmented propensity towards conflict in the family (e.g. fighting with husbands, or shouting at the children). Trauma also manifested physically (psychosomatic symptoms). In every single FGD, mention was made of family members with heart problems or "fainting spells" starting after the attacks and displacement. Other physical difficulties reported included celiac disease, asthma and constant headaches.

These manifestations are illustrated in the following quotes:

> Even in dreams, we just want to see our homes in dreams.
>
> I'm always thinking about another genocide.
>
> I get really angry when someone says something that's not the right thing, it makes me really upset.
>
> When it becomes dark I feel like we're going to have to run another time, to escape.
>
> All these come to me, for example seeing dead people—all of these all things come to my mind, when I just want to go to bed or shower. I am very nervous all the time.

Collective Trauma

Throughout the FGD and interviews, trauma was commonly referred to on a collective level. In other words, when describing the psychological impact of events on themselves as individuals, many would refer to the impact of events on "us" as a Yezidi community. Many referred to the Yezidi community as close-knit community from which it was difficult to exit or enter (we are a circle, you can't go out and find someone or bring someone inside). The suffering of one member of the community was expressed as suffering from all, with many referring to a collective "we" as opposed to individual "I." Notably, even those not directly exposed to the conflict reported experiencing symptoms of trauma.

The collective trauma, as indicated by the pronoun "we," is illustrated in the following quotes:

> We're forced to be thinking too much about relatives—not only thinking about ourselves… Yezidi are kidnapped every day.
>
> We think about relatives, so it's very difficult because of this, so it's always very new, that's why it's very difficult.
>
> When every single [kidnapped hostage] comes back, we can feel better.
>
> From my family, nobody's kidnapped but, I feel like all the whole community—when they're kidnapped I feel as if they're part of me.

The above-mentioned quotes are testament to the powerful impact of trauma on a collective level. Healing from this collective trauma is seen to be possible only "when every single" Yezidi returns unharmed. Many of the women who participated in these FGDS have directly experienced unspeakable violence and abuse at the hands of ISIS. Many have not. All are affected. As noted by Erikson (1976), in the case of collective trauma,

> 'I' continue to exist, though damaged and maybe even permanently changed. 'You' continue to exist, though distant and hard to relate to. But 'we' no longer exist as a connected pair or as linked cells in a larger communal body (p. 154).

Culturally Informed Idioms of Distress

Yezidi women drew on a variety of culturally informed idioms of distress to describe the ways in which they experience trauma, as illustrated in the following direct quotes:

> We are scared, they are always in our hearts and minds these things.
>
> Our mind is not comfortable.
>
> It's still in our all minds what they did.
>
> My very spirit changes. I have difficulty sleeping at night, I'm thinking and thinking and thinking
>
> I'm an old person because of these things that happened to me.
>
> I'm thinking a lot.
>
> It's like it's not stopping. It's always there.

Note again the use of the collective nouns—even metaphors of the mind and heart are considered in the plural ("our hearts," "our minds"). The vast majority of the idioms of distress were centred on the notion of 'thinking too much'. As noted in the literature on transcultural psychiatry, such idioms of distress include more than just ideas about the cause of an illness; they also incorporate ideas about estimating the severity of illness, appropriate treatment and the meaning of the illness. In other words, it reflects a process of sense making situated within a specific sociocultural context (Harvey, 2007; Kleinman, 1978; Maier & Straub, 2011), which should be taken into consideration by the programme design of any intervention. It is important to note that many of the women taking part in these FGD have been diagnosed with PTSD However, none referred to the diagnosis—or any related medical terminology—to describe their experiences of trauma.

Perceptions of Mental Health Services

In general, a significant shift in perceptions of mental health services among the Yezidi community appears to have occurred. Whereas before the attacks of 2014, mental health services were seen as being only for people who are "crazy" (with a significant social stigma attached)—this has now changed. Paradoxically, this shift may possibly be related to the alarmingly high levels of trauma in the community, which have led to an easier and more obvious recognition of the need for mental health support. In other words, one reason for this acceptance could possibly be due to the significant efforts the project undertook to sensitize the community about the importance of taking care of their mental health, for example by implementing psycho-education sessions. It could also be simply due to the overwhelming impact of collective trauma on this community: an impact too significant, too evident, and too debilitating to be ignored.

This shift towards a more positive perception of mental health services is illustrated in the following quotes:

> Before people were thinking it's shame, for example, if you see a doctor or a psychologist but for now for Yezidi community, it's become something very general since all of them are affected, it's something very normal and general for every Yezidi.
>
> They know what is trauma. They know that for example if the kids are traumatized then they have to be treated. It is something psychological; we shouldn't consider them as crazy or mad.
>
> I have right now, like, about 28 people, 26 waiting list [to see the psychologist], and I think that's why because right now they understand.

Case Study Two: Displaced Populations Affected by ISIS in Marawi, Philippines

Following the recent crises of extreme violence in Marawi (the country's largest Muslim-majority city) and natural disaster in two Lanao provinces, 450,000 citizens find themselves in IDP camps or 'homestays' with no own home to return to. In addition, some 1,500 families are grieving for the loss of loved ones—many under horrifying circumstances.

In response to these events, a five-member team of the Global Initiative for Stress and Trauma Treatment (GIST-T), in consultation with EMDR Philippines, Philippines Psychiatric Association, Nonviolent Peaceforce (NP) and World Bank Manila, conducted a needs assessment to understand the psychosocial impact of the recent crises in Marawi on the affected population—individuals, families, and local communities. The aim was to gather first-hand information from IDPs, review the state of current psychological services available, identify unmet mental health needs, and propose immediate and medium-term ways to strengthen capacity of mental health professionals and paraprofessionals to provide appropriate treatment. All team members participated in the data collection and information gathering, and

contributed to the development of this final report. Data and thematic analysis was undertaken by Dr. Derek Farrell.

Apart from psychometric testing, the results of which are presented in chap. 3, the following semi-structured interview questionnaire was used to interview 80 respondents from the community:

> Question 1: What happened to you?
> Question 2: Of all these things that happened to you, which one is currently bothering you the most? Which one causes you the most distress/ worst?
> Question 3: Are you able to say who your perpetrator/ assailant was?
> Question 4: Did you sustain any physical injuries?
> Question 5: What impact do you think your experiences of adverse events have had on you?
> Question 6: What impact do you think your experiences have had on those close to you?
> Question 7: Have you been feeling guilty about the trauma or your response to it? Shamed? Angry? How much have these feelings been present for you?
> Question 8: How has your mood been since the trauma?
> Question 9: What behavioural changes did you notice in yourself after the trauma experience?
> Question 10: What behavioural changes did you notice in significant others?
> Question 11: Since the trauma, have you ever thought that life is not worth living, or thought of suicide? If yes, how often?
> Question 12; What strategies/ interventions have you used in managing your trauma symptoms?

Origins and Layers of Trauma

The findings from this mission attest to the alarmingly high rates of trauma among the population. Furthermore, they highlight the substantial impact of the political, legal, and sociocultural environment on both the prevalence of trauma, as well as processes of psychosocial rehabilitation. Indeed, trauma among this population was also shown to be experienced on a complex, collective level, related to:

- Historic trauma
- Intra-familial trauma
- Religious conflict
- Violent extremism
- Sexual and gender-based violence (SGBV)
- Natural disasters
- History of forced evacuations and displacements

Intergenerational Transmission

The cycle of trauma and violence appears to have continued for generations, as indicated by the high level of adverse childhood experiences to which this adult population has been exposed. Given the significant concern raised by parents and teachers over the impact of trauma on the mental health of children in the community, the perpetuation of this cycle of trauma and violence is a significant cause for concern. The scientific literature reports that children exposed to violence and exhibiting with higher levels of trauma, have an increased vulnerability towards appetitive aggression (i.e. aggressive behaviour related to actively searching violence) and engaging in acts of extremism.

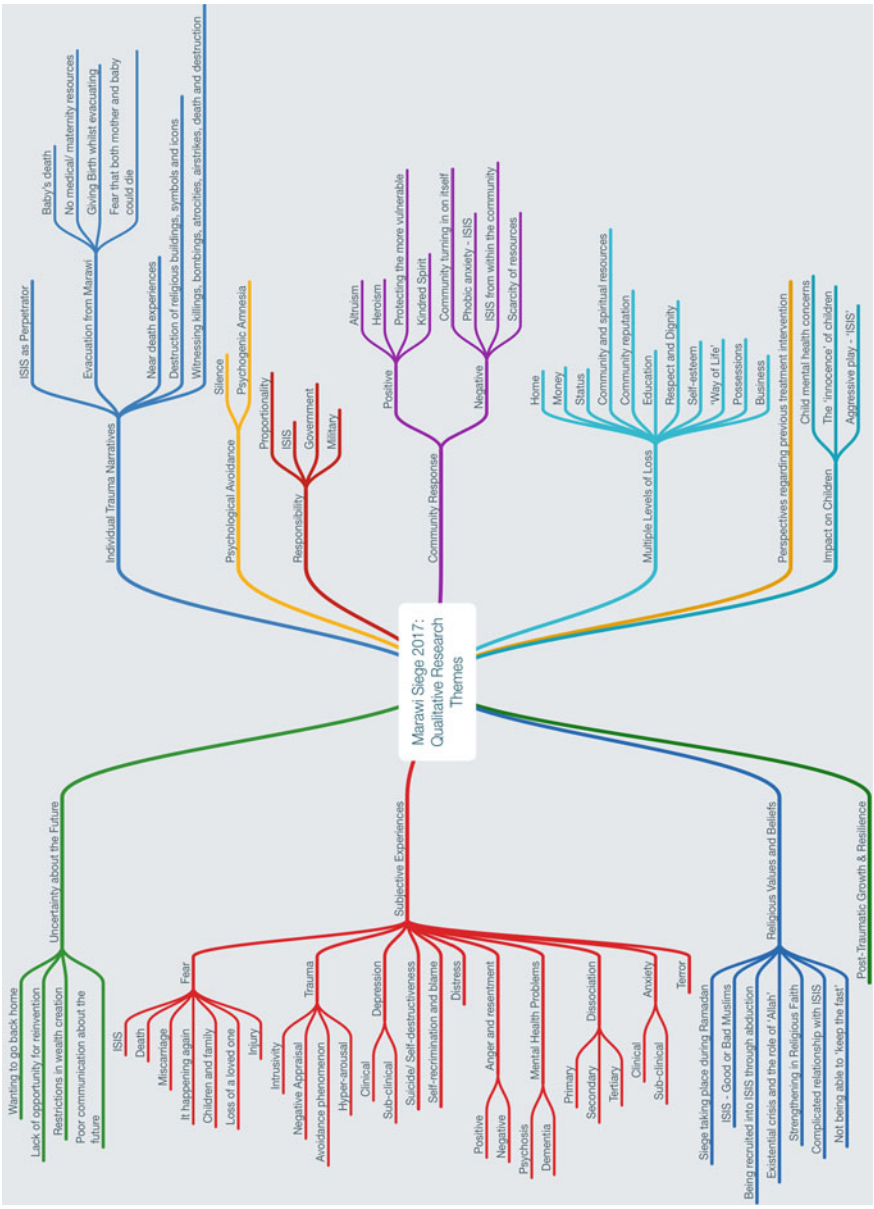
Effect on Adults and Children

Serious symptoms of depression, anxiety, and trauma were clinically observed by the consultant psychologists—confirming the results of the psychometric screening. Among the most disturbing observations was the increase in physical violence and aggression reported—particularly among the youth. Children, for example, were seen to play "Isis-Isis"—dressing up as fighters and "re-enacting" the traumatic events to which they had been exposed. Others were too afraid to attend school—jumping at the slightest sound of a motorcycle or a helicopter, as the noise would trigger memories of traumatic events. The emotional distress among adults was similarly observed to affect their ability to function productively.

Self-awareness of Trauma

The majority of actors with whom the team engaged, including the military, teachers and humanitarian workers, spontaneously referred to themselves needing psychological assistance for their own trauma—with some becoming visibly emotionally distressed/in tears when speaking about their experiences. Despite the stigma surrounding mental health in general, many spoke directly and openly about their psychological distress and need for assistance.

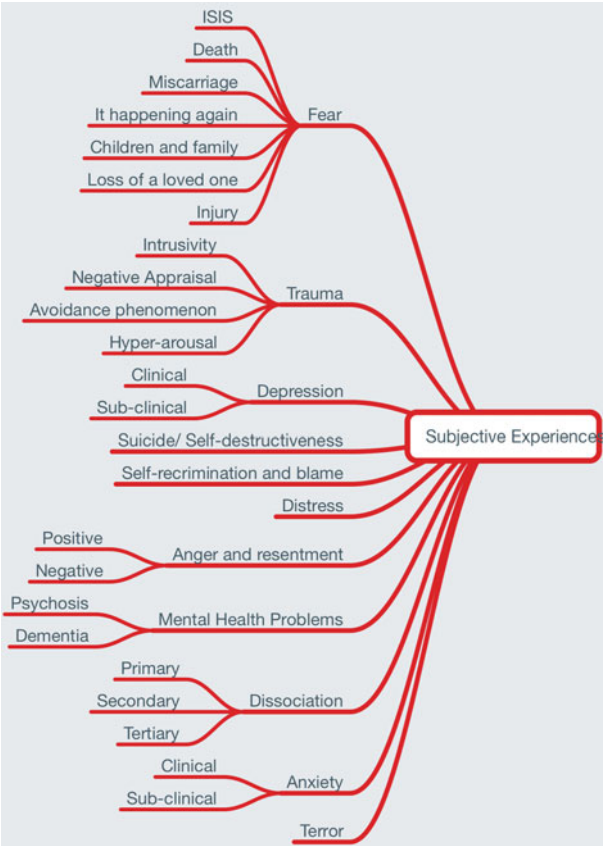
Thematic Analysis of Qualitative Data


Marawi Siege 2017: Qualitative Research Themes
Individual Trauma Narratives
ISIS as Perpetrator
Evacuation from Marawi
Baby's death
No medical/ maternity resources
Giving Birth whilst evacuating
Fear that both mother and baby could die
Near death experiences
Destruction of religious buildings, symbols and icons
Witnessing killings, bombings, atrocities, airstrikes, death and destruction
Psychological Avoidance
Silence
Psychogenic Amnesia
Responsibility
Proportionality
ISIS
Government
Military
Community Response
Positive
Altruism
Heroism
Protecting the more vulnerable
Kindred Spirit
Community turning in on itself
Negative
Phobic anxiety - ISIS
ISIS from within the community
Scarcity of resources
Multiple Levels of Loss
Home
Money
Status
Community and spiritual resources
Community reputation
Education
Respect and Dignity
Self-esteem
'Way of Life'
Possessions
Business
Perspectives regarding previous treatment intervention
Impact on Children
Child mental health concerns
The 'innocence' of children
Aggressive play - 'ISIS'
Subjective Experiences
Uncertainty about the Future
Wanting to go back home
Lack of opportunity for reinvention
Restrictions in wealth creation
Poor communication about the future
Fear
ISIS
Death
Miscarriage
It happening again
Children and family
Loss of a loved one
Injury
Trauma
Intrusivity
Negative Appraisal
Avoidance phenomenon
Hyper-arousal
Depression
Clinical
Sub-clinical
Suicide/ Self-destructiveness
Self-recrimination and blame
Distress
Anger and resentment
Positive
Negative
Mental Health Problems
Psychosis
Dementia
Dissociation
Primary
Secondary
Tertiary
Anxiety
Clinical
Sub-clinical
Terror
Religious Values and Beliefs
Siege taking place during Ramadan
ISIS - Good or Bad Muslims
Being recruited into ISIS through abduction
Existential crisis and the role of 'Allah'
Strengthening in Religious Faith
Complicated relationship with ISIS
Not being able to 'keep the fast'
Post-Traumatic Growth & Resilience

Subjective Experiences of the Marawi Siege

Within the Trauma Interview Schedule, the first question—What happened to you?—implies no negativity, blame, proportionality or indication of responsibility or prejudice. Rather, the intention is to capture a series of subjective narratives.

Question 1: What happened to you?—brings out traumatic experiences at a subjective level. Supporting narratives are given below.



Sub-theme of subjective experience

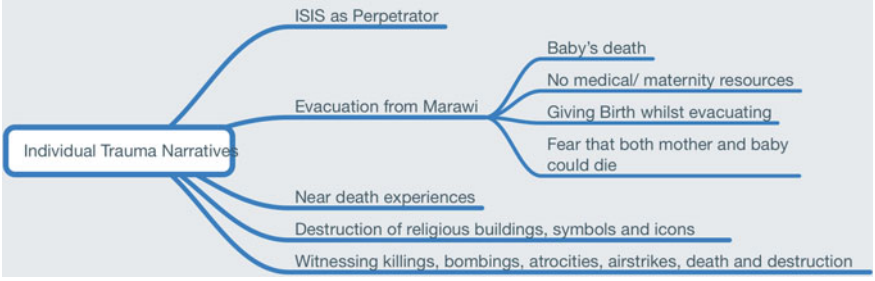
Many of the following narratives capture subordinate themes of:

- Trauma
- Terror
- Fear
- Depression
- Suicide/ Self-destructiveness

- Self-recrimination
- Distress
- Anger and resentment
- Mental health problems
- Anxiety

> What we experienced in Marawi was terrifying. On the day we evacuated we were very frightened, we had guns pointed at us, and they threatened to fire—ISIS fighters threatened to kill us. We all thought we were going to die. It is so sad to see what has happened to Marawi. We are still troubled, but we put our faith in Allah and ask for his forgiveness. My wife and children are OK—they are strong in their faith. I feel afraid all the time, but I am frightened to show this to my family. I have to be strong for them. Before I go to sleep, my mind is racing with thoughts of Marawi, replaying the experiences repeatedly. My mind races with lots and many questions. I know this experience has changed me. I try to connect more with my faith—but I am finding this difficult. I keep asking myself, why did this happen to us. Now I am very vigilant, always anxious inside, but don't want to show it. I just want the best for my children. **P19**
>
> I feel scared all of the time, helpless, experience flashbacks, anxious and very depressed. We were trapped for two days in our home. All of the mobile phones were down. When we escaped we were so frightened. We ran so, so fast to get away. We were terrified. **P38**
>
> When I think about what happened to us I experience pain and rawness—and I am angry. I am constantly asking for guidance from God. **P33**
>
> We left our home with very little, a few clothes, little money. We have lost everything. I feel stressed and anxious all the time. Even when others here in the Evacuation Centre talk about their experiences—I get agitated. It brings on bad memories. I cannot sit in any one place for any period. Sometimes I have thought that I may be better off dead. Suicide has crossed my mind. **P29**
>
> Before I go to sleep my mind is racing with thoughts of Marawi, replaying the experiences again and again. My mind races with lots and lots of questions. **P20**

Individual Trauma Narratives—Specific Focus



Sub-theme of individual narratives of note

Subordinate themes:

- ISIS as perpetrator
- Evacuation from Marawi
- Near death experiences
- Destruction of buildings, symbols and icons
- Witnessing killings, bombings, atrocities, death and destruction

I was three months pregnant when we had to escape. I was afraid for me, my husband, and my unborn child. I was petrified of losing my baby during the siege. ISIS threatened me. The worst part of the evacuation was that my father died as we were trying to escape. We could not grieve properly for the loss of our father. My baby was born here in the centre. This is no place to bring up a new baby. **P9**

At first I didn't want to leave our home. I was very scared and frightened. We had to travel on foot in order to escape. We left in a hurry which meant that we could take very little—only what we could carry. I witnessed somebody being killed right in front of me. He was killed by ISIS. It was a boy, maybe nine or ten. He had stolen some food from a local market. So, they killed him, in front of everyone. **P2**

I was born in Marawi. When the siege started, I was trapped for three days. I thought it would stop. I remember bullets hit our house. We had vehicles that we could use for escape, but none of us could drive. Eventually, when we did escape, it was on foot—ISIS fighters stopped us. They focussed on me, as they said my hair was too long. They reprimanded my father for allowing his son's hair to be too long. He ordered my father to cut it—and then they let us go. We were terrified that they were going to hurt us. There are times when I cry when I think of the happiness we had before. **P55**

I have very painful memories of the war and the siege. I have very vivid memories of the activities of ISIS fighters. We thought we were going to die. When we were evacuating we took off our shoes so that we would not be heard. We ended up with lots of cuts and injuries to our feet. I'm very concerned about my father—he is angry all the time. I just feel lonely and sad. **P46**

We were trapped in Marawi for three days during the siege (23–26 May 2017). Our house was burned and then we witnessed it being bombed. Thankfully, we were not in our house at the time. Our house was in an elevated position; we had moved to stay lower down the city. I was frightened being in Marawi as I am a Christian and this felt more scary and unsafe. We left with very little, no money—we are uncertain about the future. **P50**

During the conflict, I was nine months pregnant at the time. As we were fleeing I had to give birth to my child. It didn't go OK. I was rushed to hospital where I was operated on. I survived, but my baby died. Now I'm overwhelmingly sad and fearful all of the time. **P12**

We know that our home and business was destroyed by the siege. Loud noises are very distressing. We thought we would be separated from our family. Any loud noise makes my body shake and tremble, I have bad dreams and feel like I cannot control my emotions. We are afraid for our children that in the future they may join ISIS. We know of children who attended the Madrasa and were never seen again. As a parent, it is terrifying to lose one's children in this way. Why is this happening to us—have I not been a good Muslim, is Allah disappointed in us, in me? **P24**

The most terrifying part was that people thought we were part of ISIS, and there was a point when people turned on us, but we were able to reassure them that we were not ISIS. We were very afraid. The bombings and airstrikes were very frightening. We also came across ISIS fighters and they started to follow us. We were terrified. As we were fleeing, we all started reciting words from the Quran—like in unison, and eventually ISIS left us alone. **P18**

> 23rd May 2017. I initially thought that it was a family skirmish or conflict and thought that things would settle down. Then we got the message 'ISIS' is here. I was very distressed. We started to hear gunshots, but this is not unusual for here. Then we got text messages to say that ISIS was in the Cathedral. We initially thought it would be over in a few days, but it took five months. We were very afraid. The military cordoned off the whole area. They were afraid that ISIS fighters would try to escape. We could hear the airstrikes. We could not leave as my husband was an electrician and he was told that he needed to keep the lights on for the military. Whenever the airstrikes occurred, the ground would shake. We could often see the planes as they were flying very low. Most people left –but we had to stay. We had to feed many dogs from our Catholic community for those that fled. We were afraid that our chapel would be destroyed. We feared for our children, how would we get food, we felt unsafe. It is God's will. **P42**
>
> I'm ashamed at having to give birth on the road as we were trying to evacuate. **P6**
>
> We escaped the day after the burning of the church, school and jail. We transferred from place to place along with our neighbours. **P13**

Psychological Avoidance

Subordinate themes:

- Silence
- Psychogenic amnesia

> The whole thing is too distressing. I don't want to talk about. An ISIS fighter put a gun to my head—I don't want to talk about it. **P5**
>
> I had a near death experience—but I don't want to talk about it. I thought I was going to die. The bombings were terrible. I just want to go home. **P10**
>
> I can't remember anything about the crisis—it is all just a blank. It is all a bad memory. I struggle to remember what happened. What happened in Marawi was the will of Allah. **P25**
>
> I cannot talk about it—I do not want to talk about it. What has happened has affected all of my family. I am angry with ISIS, cannot trust ISIS people, these people are from within our community. I am angry towards the bad people, I want to kill the bad people, I am full of rage. I worry for my children. **P2**

Multiple Levels of Loss

Subordinate themes:

- Home
- Money
- Status
- Community and spiritual resources
- Education
- Respect and dignity
- Self-esteem
- 'Way of life'

- Possessions
- Business

When the siege happened, I was still at work at the university. I was about to go home when the firefight started. I called all my children and told them to go home immediately. We live close by the university. The university President asked us to stay and not leave. We witnessed the airstrikes. We did not want to show our fear and anxiety to our children. We could see the bombs exploding in the city. We were on duty day and night—we were so worried about our children. We slept in shifts to guard our children. We knew of a wife of a neighbour taken hostage by ISIS. Fr. Chito negotiated her release. When we found out that Fr. Chito had also been taken hostage—this was one of the worst parts. We prayed. However, we also know of people who lost their lives. One neighbour was hit by a stray bullet and had to have his leg amputated. Every time I see him it is a painful reminder of what happened. Now very reluctant to have conversations with Muslims—tend to stick to my own community (RC). I am afraid that they may be ISIS sympathisers and therefore our lives may be in danger. **P34**

My home was not destroyed by the airstrikes—but it has been looted. I want to go back home, but I know there will be nothing there. I desperately want to go back to Marawi—but I'm being told that I cannot go there. **P45**

We had a big shop in Marawi. It was a family business, very successful. But we lost everything. We used to be respected in the community. Now we have nothing. **P28**

We had to leave everything behind—I miss my gadgets (electronic devices). We have nothing now really—we are surviving on my late mother's pension. **P31**

We have no work, no food, and no money to start our lives again. It is just not good enough. **P41**

I lived in Marawi for five years—I have very good memories of the city. My brother came and said, 'ISIS is coming'. At 3 pm, we heard gunshots. My father was not at home. We did not know what to do, or where to go. That evening we saw ISIS starting fires. My father had a second wife in another house and at the time, he was with them. We could see that ISIS were in control of the area. During the night, we escaped and headed for the mountains. We were all very afraid. Just before the siege, my mother died so we were all still grieving for her loss. It was a bad time. Leaving Marawi—leaving all my friends and our way of life. It was a place where we could practice our religion freely—I am very proud to be a Muslim. **P44**

Because of what happened in Marawi it has resulted in the discontinuation of my education—this saddens me. We have also lost all our money and have no financial help. My mother is very distressed—this is heart breaking. We saw pictures on the news, which showed our house, it was still intact, but we are not allowed to go back there. I feel helpless and hopeless. **P65**

Community Response

Subordinate themes:
Positive

- Altruism
- Heroism
- Protecting the more vulnerable

- Kindred spirit

Negative

- Community turning in on itself
- Phobic anxiety
- ISIS from within the community
- Scarcity of resources

> We have a disabled brother and I needed to get to him to rescue him, otherwise he would have been left behind. The most terrifying part was that people thought we were part of ISIS, and there was a point when people turned on us, but we were able to reassure them that we were not ISIS. We were very afraid. The bombings and airstrikes were very frightening. We also came across ISIS fighters and they started to follow us. We were terrified. As we were fleeing, we all started reciting words from the Quran—like in unison, and eventually ISIS left us alone. **P26**

> I have experienced evacuating more than once before—the Marawi siege, and previously during the first martial law. Twice before I have been an IDP. For this Marawi siege we were trapped for four days. I'd recently had a stroke, so our neighbours had to help us to escape. Many of our neighbours were not from Mindanao—but still they helped us. I feel strong feelings of guilt that I cannot be more supportive to my family. **P49**

> Now I am very reluctant to have conversations with Muslims. I tend to stick to my own Roman Catholic community. I am afraid that there may be ISIS sympathisers living amongst us, and therefore our lives are in danger. **P33**

> I blame ISIS, but not just them; I blame the whole Islam community. I feel angry at the Muslims who support ISIS and the Muslims that fight. **P36**

Impact on Children

Subordinate themes:

- Child mental health concerns
- The 'innocence of children'
- Aggressive play

> When I notice the children playing, their play is more violent and aggressive, they fight all the time—they pretend to be ISIS fighters, and this is very difficult. I try to play with the children to help them not play in such aggressive ways. **P17**

> My children are not the same as before. They often sit and stare. They are overthinking. Their minds are distracted. I feel guilty when I see them suffering. But, I'm helpless to know what to do for them. **P44**

> I am afraid for my children for the future that they may join ISIS. We know of children who attended the Madrasa and were never seen again. As a parent this is terrifying to lose one's children in this way. **P24**

My children have lost the desire to study. I'm afraid for their future. The children are finding it difficult to adjust to being here in the camp. **P61**

When the children hear helicopters flying over they get very scared and frightened. They talk about the bombings back in Marawi. **P51**

I am very concerned about my children—they are now very aggressive. **P24**

My children are irritated most of the time. When they play it is more violent and aggressive, they fight all the time—they pretend to be ISIS fighters, this is very difficult for me to handle. **P26**

My children are always fighting, and it is more aggressive and violent than it was before. This frightens me. **P35**

The children are playing ISIS with toy guns and pretending to shoot and kill other children. They sometimes even pretend to wear the ISIS masks. They witnessed the 'Black People' during the siege. **P51**

Religious Values and Beliefs

Subordinate themes:

- Siege taking place during Ramadan
- ISIS—good or bad Muslims
- Being recruited into ISIS through abduction
- Existential crisis and the role of Allah
- Strengthening in religious faith
- Complicated relationship with ISIS
- Not being able to keep the 'fast'

This is all God's will. What has happened has strengthened my faith, and the faith of my community. We have become more resolute. **P34.**

We directly witnessed the crossfire. That this was happening during Ramadan. When we evacuated I carried a 10 kg. bag of rice, which was bought to observe the fast and the prayer. **P45.**

I liked living in Marawi. It was a place where we could practice our religion freely—I am very proud to be a Muslim. Everybody is responsible for what has happened. Marawi was becoming not a very good place. Some people were not devout in their faith. What happened in Marawi was God's punishment. I blame ISIS and the military for what happened. I'm angry with the military as it was the military that destroyed our city. **P55.**

I know this experience has changed me. I try to connect more with my faith, but I am finding this difficult. I keep asking myself, why did this happen to us. **P20.**

Why is this happening to us—have I not been a good Muslim, is Allah disappointed in us, in me? **P24.**

I feel very, very angry. We always ensured that somebody stayed in the chapel to protect it from ISIS. When we got the text message to say that Fr. Chito had been taken hostage, we all felt a lot of pain and extremely powerless. **P34.**

Uncertainty About the Future

Subordinate themes:

- Wanting to go back home
- Lack of opportunity for reinvention
- Restrictions in wealth creation
- Poor communication about the future

> My wife is very uneasy—traumatised—she is constantly angry with me. In Marawi I always knew what to do—but here in the camp nothing is certain. We have no money. **P59**
>
> I get fever when some disturbance increases. If I have lots of worries, then I get lots of physical ailments—my BP increases. Feel very different. I'm lonelier. The food here is not good, and also not enough. We are uncertain about the future and worried all of the time. **P37**
>
> A lot of worries when we think about the future, very anxious about our children, as our young children need to be fed and sent to school. I feel helpless as we have so few options. **P35**
>
> We saw pictures on the news which showed our house, it was still intact, but we are not allowed to go back there. I feel helpless and hopeless. Nobody tells us anything. **P27**
>
> I feel a lot of guilt since we have no source of income I feel ashamed as we have to either borrow or depend on others. This brings a lot of anger and shame to us, to me. **P36**
>
> We are all scared and deprived of basic needs, which never happened before. We were always well provided for. Financial difficulties are the most problematic and have impacted on our lives the most. We do not know when life will become normal again. **P38**

Post-Traumatic Growth and Resilience

> Since the siege I have become more reflective, more devout in my faith. I want to build a stronger community for the future. **P32**
>
> Now I pray more every day. I am always reading the Quran. I have recently volunteered to work for an NGO as a facilitator. **P40**
>
> I want to become a medical doctor in the future. Marawi was not a good place. There were females not wearing their veils—and doing bad things. The markets were not clean, and the water was dirty, waste management was not good. When it rained and the sun came out, the smell was terrible. It was so bad that it affected the health of the children. Having EMDR therapy with Fr. Cornelio was very helpful. It helped me understand my feelings, what I was encountering and experiencing. It helped me process the trauma through the drawing and BLS (Butterfly Hug). The memories are always there—but now they are more distant and feel in the past. We did a three-day training with Fr. Cornelio, which was good experience in sharing. I know for certain that I want to live my life by helping others. **P55**
>
> There are times when I cry when I think of the happiness we had before. We have been taken into this Christian community—they have been very good and kind to us. I did not see good in Christian people before—I have always seen them as bad people. However, my view has changed—I see Christians differently now—I can accept help from my Christian neighbours. **P56**

> What has happened to us is hard, but it has brought my family closer together. We support one another. We will get through this—and be stronger again as a community. Marawi will be a stronger city in the future. **P1**
>
> My relationship with God is stronger now. Allah is the answer to all our problems. **P48**

Conclusion

These case studies highlight the substantial impact of the political, legal and sociocultural environment on both the prevalence of trauma as well as processes of psychosocial rehabilitation. Indeed, trauma among this population was also shown to be related to collective and historic trauma experienced on a community level. One of the key themes to emerge from the case of the Yezidi community was the significant emotional impact of having members still held hostage, lost or missing. On a collective level, this appears to have resulted in unresolved, ongoing trauma. For many, the uncertainty as to whether or not their loved ones were alive or dead appears to have complicated the mourning process. Some individuals in the project report feeling as though they are "frozen" in this liminal space, unable to start on the important and necessary work of grieving. Hope that loved ones may still be alive is a double-edged sword—keeping many stuck on a perpetual loop of acute and intense pain, unable to proceed along the emotional journey of mourning. Here, we think of the symbolic importance of mass memorials such as the case of countries such as Rwanda and Bosnia, where rituals of mourning have offered some possibility of healing from this complicated, collective grief. The trauma is irrevocably collective, symbolic and political—as are healing mechanisms. If trauma may be experienced collectively, it stands to reason that processes of healing should similarly be facilitated collectively.

This similarly speaks to a need to consider the political context in which the intervention takes place. For example, the Free Yezidi Foundation programme incorporates an advocacy strategy targeting those directly affected (notably enslaved women and girls), as well as the international community. A sense of justice being served through the social recognition of this suffering (Marková, 2016) is integral to the healing process. Collective and historic trauma does not occur in a sociopolitical vacuum, and neither should intervention strategies. As noted by Yassin et al. (2018), "although interventions at the micro and mezzo levels are extremely helpful, radical changes do not occur without implementing support and strategic interventions at the macro level" (p. 9).

Implications for interventions include utilising eco-social frameworks for research and practice, engaging in advocacy, and establishing agendas for mental health practice that emphasise individual and collective self-determination (Harvey, 2007; Sousa & Marshall, 2017). Understanding the collective impact of dislocation, trauma and loss, of political persecution and human malevolence, and social systems involving abuse, neglect, and ethnic and cultural rejection, is crucial in terms of guiding policy makers and clinicians to assist, and as advocates to address, the social, cultural and political perspectives of trauma. Furthermore, it is fundamental to the success

of any mental health intervention targeting displaced populations. Attending to the mental health needs of trauma survivors, including interdisciplinary rehabilitation from trauma, is a key part of restoring dignity in the wake of human rights abuses and providing a form of justice for those who suffered harms.

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