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RESEARCH ARTICLE

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A mutual process of healing self and healing the community: A qualitative study of coping with and healing from stress, adversity, and trauma among diverse residents of a midwestern city

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Abstract

Residents of urban American neighborhoods facing economic hardship often experience individual and collective adversities at high levels. This study explores how racially diverse adults experience stress, adversity, and trauma, and how they cope and heal in the context of their environment. Following a critical realist grounded theory methodology, four focus groups were conducted with African American, White and Latinx participants ($N = 21$) within an employment service program. Participants identified key stressors ranging from financial and job challenges, violence, and trauma. To cope with and heal from adversity, they practiced positivity, named trauma and its effects, sought social connection, envisioned community-based resources, and addressed structural and systemic barriers. The data generated a theory of "a mutual process of healing self and healing the community" through intrapersonal, interpersonal, and structural change. The results of this study indicate a need for peer-led, community-engaged initiatives and holistic, trauma-informed, healing-centered practices.

This study was approved by the institutional review board of the University of Wisconsin-Milwaukee, in accordance with human subjects protections standards.

All participants of this study were enrolled with an informed consent process, and pseudonyms were used for all participants and the program from which they were recruited.

KEYWORDS
African Americans, focus groups, grounded theory, poverty, psychological resilience, psychological trauma, urban populations

1 | INTRODUCTION

Lifetime exposure to stress, adversity, and trauma are well recognized problems across the general population (Anda et al., 2010). However, these adversities are often concentrated among people living with poverty and systemic racism, and who have experienced historical trauma (Sotero, 2006; Williams, 2018). This is congruent with findings from a larger study from which this current study's sample was drawn; the racially diverse job-seeking participants in the parent study were found to have a comparatively high level of exposure to adverse experiences and positive post-traumatic stress disorder (PTSD) screening results (Topitzes et al., 2019). This larger study initiated a trauma-informed intervention with job program participants throughout Milwaukee, with the aim of increasing access to mental health supports and thereby assisting with job retention. Researchers found that while participants reported multiple sources of stress and adversity, they also named an expansive range of helpful coping strategies (Topitzes et al., 2019). These findings led the authors to the aims of this study: to explore qualitatively how people experience stress, adversity, and trauma, and how they cope and heal in the context of their urban setting.

This context is important because an individual's exposure to stress, adversity, and trauma may be experienced within a broader context of historical trauma, structural racism, and other forms of discrimination (Sotero, 2006). The adversity and trauma can therefore be shared with a wider group. While individual reactions to shared traumatic events and circumstances generally vary, the collective and contextual nature of the trauma strongly influences each person's experience and reactions (Sotero, 2006). This study is framed within a context of inequality that influences multiple levels of adversity (e.g. individual, family, and community) and explores how people respond to adversity, individually and collectively (Ginwright, 2018; Tuck, 2009). These ways of responding include personal coping practices, as well as cultural strengths, wisdom, and healing that are grounded in the community (Tuck, 2009). The current study reflects a broad, socioecological view of trauma and recovery, in which environmental context, social processes, and historical and collective trauma condition individual experiences (Harvey, 1996; Maercker & Hecker, 2016; Ungar, 2011a).

The authors of this study first review literature that contextualizes the stress, adversity, and trauma affecting people of color and White people living with low incomes in urban American settings. Research explaining historical and current collective trauma, along with subsequent intergenerational effects, is discussed. Next, literature examining societal disparities and problems, race-related and poverty-related stress, and exposure to community violence is presented. Subsequently, the historical, ecological, and cultural context of healing is discussed. Finally, authors review research about coping and healing at the individual, family, and collective (e.g., social cohesion) levels for these populations.

2 | LITERATURE REVIEW

2.1 | Stress, adversity, and trauma in context

2.1.1 | Historical trauma

Historical trauma, a concept originally developed by Maria Yellow Horse Brave Heart in the 1980s, is the "cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences" (Brave Heart, 2003, p. 7). Sotero (2006) describes the underlying assumptions of

historical trauma, noting that to be considered such, a mass trauma must be deliberately and systematically inflicted by a dominant population against a target population, resulting in disparities across generations that are psychological, physical, social, and economic. For Native Americans, a history of forced displacement, colonization, and genocide at the hands of European Whites who came to the Americas represents historical trauma (Brave Heart, 1998). For African Americans, examples of historical trauma include, but are not limited to, the profound mass injury and loss inflicted by Whites through transcontinental slavery, racial lynchings, Jim Crow laws, colorism (see Ortega-Williams et al., 2019), and mass incarceration.

Research suggests a wide range of intergenerational effects on the health and wellness of populations exposed to historical trauma. Segregation/displacement, physical and psychological violence, economic destruction, and cultural disruption are conceptualized as the social pathways that sustain mass group-level harm and are associated with disparities in health (Sotero, 2006). These effects include elevated risk for domestic violence, physical and sexual abuse, substance abuse, and suicide (Danzer et al., 2016; Sotero, 2006). Other possible negative psychological effects of historical trauma include prolonged or unresolved grief, disruption of original spiritual practices, anger and aggression, hypervigilance, and psychic numbing (Brave Heart, 1998; DeGruy-Leary, 2005; Williams-Washington & Mills, 2018). Scholars have theorized and begun to measure the ways in which historical trauma may produce health and economic disparities, in the context of persistent discrimination and continued systemic violence (Brave Heart et al., 2011; Degruy-Leary, 2005; Sotero, 2006; Walters et al., 2011; Whitbeck et al., 2004).

2.1.2 | Societal disparities and problems

Examples of societal disparities related to historical trauma and ongoing systemic racism abound. According to 2019 census data, the rate of poverty is higher among African Americans (18.8%) and Latinx (15.7%) than among Whites (9.1%). Research suggests that inequities in skill acquisition and discrimination in hiring and wages contribute to racial employment disparities (Pager & Shepherd, 2008). In 2020, the unemployment rate for African Americans was nearly twice that of Whites, and the COVID-19 recession is disproportionately affecting African American and Latinx workers (U.S. Bureau of Labor Statistics, 2020). In addition, due to factors including structural inequity, racist policies and practices, and implicit bias in the criminal legal system, African American men are 5.1 times as likely to be incarcerated as White men, and African American women are 2.8 times as likely to be incarcerated as White women (Nellis, 2016). Disparities based on socioeconomic status impact people of all racial and ethnic backgrounds. For example, individuals with low incomes, who are at greater risk of being uninsured or living in detrimental environmental conditions, experience poorer health outcomes (Dubay & Lebrun, 2012).

2.1.3 | Race-related stress

Considering these and other disparities, it follows that race-related stress and discrimination play a role in the context of adversity that many people of color experience on a daily basis, which in turn affects their overall well-being. Racism, a social determinant of health, has been shown to have a negative association with health outcomes, especially mental health (Paradies et al., 2015). In an overview of research on the mental health effects of race-related stress for people of color, Williams (2018) highlights the way social disadvantage and stressors cluster together triggering stress proliferation processes, and in turn mental health problems. A wide range of studies have found strong associations between social determinants of health—such as discrimination, segregation, concentrated poverty, and aggressive policing—and symptoms of mental health disorders (Williams, 2018). Additional research with African Americans finds that race-related stress is a stronger predictor of psychological distress than stressful life events (Utsey et al., 2008) and is significantly linked to low life satisfaction (Driscoll et al., 2015).

2.1.4 | Poverty-related stress

Stress and adversity related to poverty also contribute to mental health issues. Research indicates that low socioeconomic status increases the likelihood of psychological disorders, and this effect is mediated by economic stress (Hudson, 2005), lending support to the idea that poverty-related stress significantly predicts mental health disorders. Childhood poverty is strongly correlated with more frequent and intense adverse childhood experiences and a variety of negative outcomes in health and well-being over the life course (Anda et al., 2010; Brooks-Gunn & Duncan, 1997). Poverty-related stress is directly related to symptoms of anxiety and depression along with social problems; furthermore, neighborhood disadvantage is associated with a higher risk for psychological syndromes (Santiago et al., 2011).

2.1.5 | Community violence

Living in urban communities, often accompanied by neighborhood disadvantage related to prolonged disinvestment and other structural forces, is associated with heightened exposure to violence (U.S. Department of Justice Federal Bureau of Investigation, 2018) and concomitant psychological distress. Studies have found positive associations between witnessing and experiencing violence in urban settings and mental health problems (Clark et al., 2008; Gaylord-Harden et al., 2017). Studies examining racial differences in trauma exposure have found that urban-dwelling African Americans who are socioeconomically disadvantaged have greater rates of exposure to assaultive violence compared to the general population (Alim et al., 2006; Breslau et al., 1998; Roberts et al., 2011). Additionally, while the unexpected death of a loved one is one of the most common traumatic events for the population at large (Breslau et al., 1998; Ogle et al., 2014), it is more frequent across the life span for African Americans, who experience both shorter average life expectancy and greater exposure to violence (Umberson et al., 2017).

This context of historical trauma, societal disparities, race-related stress and discrimination, poverty-related stress, and community violence exposure is essential for understanding the ways in which people who live within this context cope and heal.

2.2 | Coping, recovery, resilience, and healing

2.2.1 | Historical, cultural, and ecological context of healing

People living in urban communities, specifically those without living wages or wealth, continue to show resilience, strength, and self-determination, in spite of stress, adversity, and trauma. Resilience is defined as a process that occurs in the context of adversity, whereby the individual and their social and physical ecologies interact to protect against risks and facilitate growth (Ungar, 2011a). For people of color, this may be due to the intergenerational transfer of wellness from factors that buffer against historical trauma, such as "original instructions" from one's culture (i.e., teachings about how to live and interact in the world), historical tools of resistance, and healing knowledge (Beltrán et al., 2018; Walters et al., 2020).

African American families have initiated strategies to survive and thrive by utilizing certain common cultural attributes, such as achievement orientation, work ethic, flexible family roles, kinship bonds and religious orientation (Hill, 1999). Collectively, African Americans have also thrived by establishing independent community institutions and mutual aid networks (Carlton-LaNey, 1999). In a national sample, African Americans were found to extensively use reciprocal support networks that include extended family, friends, and church members (Taylor et al., 2016). In addition, African American cultural values and group-specific practices such as communalism,

central-internalized racial identity, cultural spirituality, positive racial socialization, and effective racism-related coping were found to be associated with psychosocial health; certain strategies were related to decreased depression, anxiety, and other symptoms of psychological distress (Johnson & Carter, 2019). For Latinx families, cultural values and practices that include spirituality and religion, familism, social cohesion, and collectivism have been found to promote healing (Weisman, 2005). Moreover, Latinx individuals may apply cultural resilience strategies that include an interdependent approach and active coping to overcome challenges and systemic barriers (Comas-Díaz, 2006).

These cultural attributes speak to the ways in which people of color continue to cope, heal, and fight back against adversity that exposes them to trauma at the individual, family, and communal level. Recognizing and uplifting the strengths of people of color and working-class White people shifts the dominant paradigm of assessing and addressing trauma at the individual level only or using deficit-oriented models (Brice & McLane-Davison, 2020). Some scholars suggest that trauma recovery and resilience occur at multiple levels of a person's social ecology, and recommend broadening the way we understand trauma recovery and resilience by examining the potential of communities to facilitate growth (Brice & McLane-Davison, 2020; Harvey, 1996; Maercker & Hecker, 2016; Ungar, 2011a). Strengthening community is associated with decreased PTSD symptom severity (Harvey, 1996; Maercker & Hecker, 2016; Ungar, 2011b). Furthermore, to advance the field of trauma studies, Ginwright (2018) introduces the notion of "healing-centered engagement," an approach that views the person holistically. It promotes wellness by first recognizing the collective nature of certain forms of trauma and cultural and collective modes of healing. With this frame in mind, literature related to specific coping and healing among African Americans and ethnically and racial diverse people living in urban communities is reviewed.

2.2.2 | Individual-level coping and healing

Individual level coping and healing strategies may include spiritual beliefs and practices, efforts to manage or adapt to stress, and how one feels about or reacts to stressful situations. Research suggests that African Americans tend to draw on and benefit from religious coping (Bradley et al., 2005; Hays & Aranda, 2016; Ward et al., 2013). Faith-based mental health interventions–many of which focus on increased knowledge of mental health issues—may be associated with an improvement in mental health outcomes (Hays & Aranda, 2016). In a study with African American adults who had experienced severe forms of trauma, results pointed to an association between certain psychosocial factors (e.g., purpose in life and mastery) and trauma recovery and resilience. Moreover, research suggests that African Americans with low income employ certain emotion-focused coping strategies at higher rates than Whites with low income; both African Americans and Whites with low income reported higher overall use of coping strategies as compared to middle class Whites (Brantley et al., 2002). Other studies have found that primary control (direct efforts to manage a stressful situation and one's reaction to it) and secondary control (adapting to the stressful situation) coping strategies protect against psychological syndromes in ethnically diverse (Latinx, White, and African American) families coping with poverty-related stress (Wadsworth & Santiago, 2008; Wadsworth et al., 2011).

2.2.3 | Family-level coping and healing

Coping and healing from stress and trauma also occurs within the family unit. For instance, culturally relevant or Afrocentric parenting practices (e.g., racial socialization and reinforcement of cultural identity) have been found to promote resiliency among youth enduring race-related or neighborhood stressors (Coard et al., 2007; Whaley & McQueen, 2004). In addition, social support from family and other family-related factors (e.g., maternal closeness) are instrumental in decreasing or buffering against depressive and anxiety symptoms among African American adolescents in urban settings (Hammack et al., 2004; Lindsey et al., 2010). Family adaptability and cohesion can

mitigate race-related stress (Utsey et al., 2008). Moreover, "family-based, coping-focused interventions" have been found to foster resilience among ethnically diverse (Latinx, White, and African American) family members experiencing poverty-related stress (Wadsworth & Santiago, 2008).

2.2.4 | Social and neighborhood-level coping and healing

Social support (inclusive of family, friends, and other members of one's social network) is an essential and effective component of coping and healing (Brewin et al., 2000; Prati & Pietrantoni, 2010). Social support has been found to buffer against race-related stress among African American adults (Odafe et al., 2017), protect against PTSD symptom severity among African American and White women with low incomes (Schumm et al., 2006), and facilitate mental health service use (Motley & Banks, 2018). Extended family and community support networks are associated with resilience among Latinx families (Cardoso & Thompson, 2018). Social support also serves to help adults of diverse ethnic backgrounds manage poverty-related stress (Broussard et al., 2012; Gazso et al., 2016). However, social support on its own may have limited efficacy, particularly among individuals living in high poverty and high crime contexts (Ceballo & McLoyd, 2002; Raikes & Thompson, 2005).

Neighborhood and community dynamics—such as the level of social cohesion and sense of collective efficacy—also play an important role in buffering against the effects of stress and adversity among urban dwellers. A study of trauma-exposed individuals in Detroit found that individuals in neighborhoods with high social cohesion are significantly less likely to have had PTSD in the past year than those in neighborhoods with low social cohesion (Johns et al., 2012). Collective efficacy, defined by Sampson et al. (1997) as "social cohesion among neighbors combined with their willingness to intervene on behalf of the common good" (p. 918), is associated with reduced community violence. It can be enhanced via friend/kinship networks, among other factors (Morenoff et al., 2001). Studies suggest associations between collective efficacy and greater life satisfaction (Driscoll et al., 2015), better self-reported health (Browning & Cagney, 2002), increased confidence in the ability to make neighborhood improvements (Rice et al., 2016), and protection against the effects of racial discrimination (Driscoll et al., 2015).

2.3 | Study goals

This literature provides a broad view of the ways in which people of color and Whites in cities across the United States may experience stress, adversity and trauma, and how these experiences may be both individual and collective. When combined, the research examining ways in which people cope and heal also demonstrates that there may be multiple dimensions of healing. While many studies have examined coping, resilience, and posttraumatic growth or recovery, much of the research has focused on one or more variables, offering a variable-centric perspective. This research fills a gap by providing a contextualized, strengths-based, person-centric perspective that focuses on lived experiences and real-life implications. Furthermore, this study presents an expanded understanding of stress, adversity, and trauma and an emergent theory to explain a multidimensional healing process. This study explores two questions: How do urban-dwelling adults within an employment service program experience stress, adversity, and trauma? How do people cope and heal in the context of their urban environment?

3 | METHODS

Grounded theory methodology was used at all stages of research (i.e., design, data collection, and analysis) to develop an understanding of a phenomenon that is not widely known, and to uncover an explanatory process or theory grounded in the data (Charmaz, 2006; Glaser & Strauss, 1967). In particular, this research applies a critical

realist grounded theory methodology, which is well-aligned with the practical and ethical foundations of fields such as community psychology and social work (Oliver, 2012). Critical realist grounded theory follows an emancipatory agenda, seeking to critique and transform by contextualizing explanations for individual experiences, and examining social structures and how they affect what is seen in the data (Corbin & Strauss, 2008; Oliver, 2012). This methodological approach was deemed suitable due to its attention to both the individual and the wider society (i.e., how individual experiences are located within context of larger events), while sticking closely to emergent patterns grounded in the data.

Given the importance of social and collective processes in this study, the authors chose focus groups as the method of data collection. The group interaction or "group effect" of these researcher-facilitated, focused discussions help reveal complex behaviors and motivations (Morgan, 1996). Moreover, focus groups help unveil social realities of a cultural group (McLafferty, 2004). Consistent with the goals of critical realist grounded theory, this method led to the development of an integrative story that considered deeper structures and hidden meanings (Oliver, 2012). The focus group members were all clients of a program where group processes and interactions were the norm.

3.1 | Sampling, recruitment, and eligibility

Members of the focus groups were recruited from a larger sample of adult participants involved in research addressing mental health needs for clients of employment service programs in Milwaukee, Wisconsin, a major Midwestern city. Purposive sampling was employed to recruit focus group participants who were a part of the broader study at one site, and who were willing, available, and interested in sharing their experiences of stress, adversity, trauma, coping, and healing. Participants were eligible for this qualitative study after completing a trauma-focused interview conducted at one of the employment service programs, referred to here as "Work Matters." This program was deemed a suitable site from which to recruit participants due to the steady, collaborative relationship between researchers and staff, and between staff and clients. The program serves mostly African Americans and is located in a predominately African American neighborhood within a highly segregated metropolitan area (Frey, 2018). An employee of Work Matters assisted researchers by attempting to contact 80 eligible focus group participants. A total of 25 individuals were scheduled to attend the four focus group sessions, with 21 individuals ultimately participating.

3.2 | Procedures

Each of the four focus groups lasted approximately 90 minutes, with three to seven participants in each group. Participants received a $40 gift card as compensation for their time. Focus groups were moderated by the fourth author, an African American associate professor with a long-standing history of conducting qualitative research with African Americans in urban settings. He established credibility and rapport with the participants by sharing his positionality, personal experience, professional history, and research expertise. The first two authors, who identify as White and multiracial, respectively, assisted with the informed consent process, audio recordings, note taking, time keeping, question prompts, and incentive payment processing. The focus groups were held on site at Work Matters; an African American employee of the program attended three of the four group sessions with the consent of participants. The research team racially and ethnically reflected the study participants. The University of Wisconsin-Milwaukee's Institutional Review Board approved the study's human subjects' protections plan. Researchers obtained consent from all participants, for whom pseudonyms are used, before initiating focus groups and audio recording.

3.3 | Participants

A total of 21 adults participated in the four focus groups. Seventeen participants identified as African American (81%), three as White (14%), and one as Latina (5%). They ranged in age from 20 to 59, with a mean age of 35.7 years old, and were equally divided cisgender male/female; no one identified as gender expansive (see Table 1 for demographic information for each participant). Participants entered Work Matters due to unemployment and were typically presumed to have low or no income at that time, though current income level was not recorded at the time of the focus group and many had by then gained employment.

Three of the four focus groups were composed of African American participants only. Researchers observed somewhat different dynamics and content discussed in the fourth focus group, which was the sole group that included non-African American members and was largely composed of older participants in comparison to the other groups (average age 44, as compared to average ages of 29, 33, and 38). One member of this group, a White woman in her early 50s, had professional employment in mental health care at the time of the focus group. She and two other older participants—a Latina woman in her late 50s and an African American man in his 40s—were the most outspoken participants in this group and seemed to freely discuss their experiences and insights, which were highly varied. These three spoke more in depth about their specific traumatic experiences than other participants

TABLE 1 Participant demographic information

Participant pseudonym (alphabetical)	Focus group	Race/ethnicity, gender, and age
Brenda	4	Other/Latina, female, 59 years old
Bridgette	2	African American, female, 23 years old
Derrick	4	African American, male, 40 years old
Dominique	2	African American, female, 36 years old
Elaine	4	White, female, 51 years old
Henry	4	White, male, 37 years old
Kenneth	3	African American, male, 33 years old
Kimi	1	African American, female, 24 years old
Korey	2	African American, male, 26 years old
Lawrence	4	African American, male, 21 years old
Malcolm	2	African American, male, 33 years old
Mary	4	White, female, 56 years old
Michael	3	African American, male, 30 years old
Nadia	1	African American, female, 28 years old
Naeem	2	African American, male, 38 years old
Odette	3	African American, female, 52 years old
Samuel	2	African American, male, 22 years old
Shaun	1	African American, male, 20 years old
Teresa	1	African American, female, 55 years old
Tiana	2	African American, female, 27 years old
Victoria	1	African American, female, 40 years old

across groups. The three groups that were exclusively African American members sometimes spoke in a way that assumed that there was common knowledge between participants (and sometimes the moderator) about African American neighborhoods and experiences. In contrast, the African American and Latinx participants in the fourth group had occasion to spell out how their experiences may have differed from White participants. In general, researchers observed that men and women (evenly split within groups), whether African American, Latinx, or White, spoke freely.

3.4 | Data collection and analysis

The semi-structured focus group interview protocol was developed collaboratively among all five authors, with attention to the literature related to trauma recovery and healing among people of color and people with low socioeconomic status. Focus group questions were designed to elicit data related to participants' stress and adversity, and their means of coping and healing both individually and collectively. Examples of focus group questions included: What are some things that make for a good day or week/bad day or week? What are good times and hard times like where you live? What helps you (and your friends and family) get through hard times or challenges? What do you and those around you do to heal? What do you dream could be possible in the future where you live that isn't happening yet?

Focus groups were digitally audio-recorded, then transcribed by a social work doctoral student. Transcriptions were reviewed for accuracy by the first and second author before analysis. Following the constant comparative analysis method (Glaser & Strauss, 1967), audio, notes, and transcript data were collected and analyzed concurrently; concepts and themes that emerged from each focus group guided the subsequent focus group discussions. For instance, "positivity" and interpersonal "negativity" were often mentioned by participants during the early focus groups, thus it was determined that the moderator would probe further into these concepts in subsequent groups.

The analysis of data followed a sequence that began with open coding, followed by axial coding, and concluded with selective coding (Corbin & Strauss, 2008). In the initial stage of open coding, the first author reviewed transcripts line-by-line and organized data using descriptive and concrete terms, for example, "starts with self" and "lacking social connection." The first two authors compared, questioned, and reached coding consensus through the development of a codebook with over 200 codes, with further review and refinement of codes and concepts completed with the rest of the research team. Using a wide range of codes, researchers performed axial coding to develop conceptual level categories and identify relationships between codes and categories. Concepts were examined and discussed to identify potential core phenomena or themes along with surrounding factors. For instance, because experiencing interpersonal negativity versus practicing positivity was one of several emergent themes, the causes, conditions, strategies, and consequences of this phenomenon were explored. Finally, selective coding was performed, in which connections were drawn between concepts and categories to generate major themes and processes, and ultimately, theory (Corbin & Strauss, 2008). Following the critical realist grounded theory approach (Oliver, 2012), researchers considered multiple theoretical frameworks and contextual explanations of the selected phenomenon, creating visual aids to facilitate examination until a theory with the strongest explanatory value was agreed upon.

3.5 | Rigor

This study employed several strategies to enhance rigor, that is, to meet the criteria of credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Multiple researchers, of varying backgrounds and positionality, involved in the study design, data collection, and analysis helped to enhance researcher reflexivity and

minimize bias (Padgett, 2008). The authors engaged in peer debriefing (Padgett, 2008) between each focus group and at every level of analysis. To further explore ideas and concepts emerging in the data, the authors used theoretical sampling (Glaser & Strauss, 1967) with new questions in subsequent focus groups. In addition, member checking was done between focus groups with different participants (e.g., "We heard x from participants in the last focus group. What do you think about that?"; Morse, 2015). Negative case analysis, where disconfirming evidence is evaluated, was performed to avoid missing meaningful data that might not fit patterns or themes observed within focus groups (Padgett, 2008). This strategy identified coping strategies that did not fit for each participant (e.g., being close to family members vs. setting boundaries with family members), but did not disconfirm the emergent theory. An audit trail (Lincoln & Guba, 1985) was created, consisting of a record of written notes, graphic depictions, and photographs of visual representations on paper or whiteboard. In addition, thick description was employed by contextualizing the data collection, analysis, results and implications of this study within the larger social, cultural, and political environment of participants (Lincoln & Guba, 1985). These methods led researchers to a set of multidimensional findings and emergent theory.

4 | RESULTS

The grounded theory methods of analysis generated a theory of a mutual process of healing self and healing the community, by means of intrapersonal, interpersonal, and structural change. This theory of bidirectional healing was reached through a process of relating conceptual level categories that were then drawn into two overarching themes corresponding to the two research questions: (1) how adults experience stress, adversity, and trauma, and (2) how adults cope with and heal from stress, adversity, and trauma. The first part of this section addresses the theme of experiencing stress, adversity, and trauma. Conceptual categories identified through the coding paradigm include encountering and navigating violence and crime in the community, identifying trauma and its associated symptoms, dealing with financial hardship, sensing interpersonal negativity, lacking social connection and interaction, lacking adequate community-based resources, and identifying structural and systemic barriers. The second part of this section details the findings relating to coping with and healing from stress, adversity, and trauma, addressing the second research question. Conceptual categories within this theme fall within individual (e.g., activating self-efficacy and self-determination), family (e.g., motivated by family/children), collective (e.g., bonding with others), and structural levels.

4.1 | Experiencing stress, adversity, and trauma

Focus group participants spoke of many different types of stress and adversity that they experienced, and some made more direct statements about a history of trauma exposure. The adversity was sometimes experienced individually, sometimes collectively, and often both.

4.1.1 | Encountering and navigating violence and crime in the community

Participants frequently discussed high crime rates, the unpredictability of what could happen on any given day, the need to stay inside the home to avoid trouble, and generally feeling unsafe in their current or former neighborhoods. Shaun described the city as "a place where we have a lot of shootings, robbings, killings, high speeds." He added, "am I gonna really risk my life to get in this car, or I'm just gonna stay at home today? And that's a battle for everybody every morning." Focus group members also mentioned risks to their safety within their neighborhoods as a result of police "driving up the one way, doing 50 [mph]" or knocking on your door asking about things the

study participants do not feel safe or comfortable discussing. Explaining the neighborhood environment of crime, violence, and police surveillance, Naeem said, "it's like a jungle, man, you know?"

Staying at home was frequently mentioned as a means to stay safe and cope with the realities of the neighborhoods in which study participants lived. Many mentioned that while they did not necessarily like children overusing video games and social media, they felt that use of technology inside the home was safer than youth and children being out on the street. Others had moved to safer areas or were making plans to do so. Victoria, a mom of three children, explained that all she does is work and come home because she lives in a neighborhood that is referred to as "the zoo." She stated "I'm trying to get up out the jungle. Really like literally it's… to each is their own." Dominique and her two young daughters had recently moved, saying she felt unsafe in their neighborhood and limited in their daily activities. Naeem had also recently moved due to an armed home invasion in his family home.

Some discussed how community violence becomes normalized. In Brenda's case, the violence began in the home and radiated out into the community: "My father used to beat me and my mom all the time. So I was always out fighting everybody because if I didn't see violence… I didn't think it wasn't normal." For Derrick, violence and crime have been pervasive beginning with his teen years. He explained how different people react to potentially traumatic events based on what they have already been exposed to in their lives. Referring to another focus group member, he said "let's say, if he sees a shooting, it's probably going to shake him up. I done seen a couple people get shot, hell I got shot. I got shot in the stomach, it's just normal." He added, "just another day where we at." Korey recounted stories of violence occurring around him but not feeling fazed by it, and agreed when Tiana responded,

> I think a lot of people suffer from PTSD and don't really know it. Like what he's saying, he's so used to, it's like he could see somebody get shot right in front of him and it wouldn't really bother him as much…because that's a part of his environment.

4.1.2 | Identifying trauma and associated symptoms

The discussion about normalization of violence tied into comments such as Tiana's about PTSD and the identification of trauma and associated symptoms within themselves and the community at large. Participants spoke of a range of traumatic events or situations, such as childhood abuse, domestic violence, loss of a child, and assault with a weapon. Many discussed the effects of trauma on mental and behavioral health (e.g., PTSD, depression, substance abuse). Kenneth, for instance, spoke of being excessively bullied throughout his childhood. As a result, he experiences issues with defensiveness, anger, and hypervigilance: "Because of that, I'm always at attention. You know, I can notice from a whole block away, somebody walking down the street. I don't know what your intentions is walking down the street. I'm ready. My guards is up." Nadia reinforced the point: "Whether it's poverty, car accidents, abuse, gunshots. A lot of people here are very traumatized."

4.1.3 | Dealing with financial hardship

Financial hardship among participants or their family members was a source of stress.

Some participants talked about debt. Odette and Michael mentioned having to help their parents or adult children with rent or other basic needs on a regular basis. Elaine discussed the troubles she endured while underemployed for over 4 years despite possessing a college degree, while Michael spoke to a chain of events that can occur due to chronic financial struggle and unemployment:

> People on a daily basis it's hard to get a job. Take a toll on a person, you know what I'm saying? Then they get depressed and all that. You know, things come up and they don't got the money to get there and all that such thing. Then they do something stupid, police become involved, and now the whole system against you.

Kenneth experienced this firsthand, detailing how he was out of work for a long time and gradually began stealing metals from abandoned houses, which led to incarceration and ongoing supervision. Derrick also made an explicit connection between poverty and crime, by discussing the lack of opportunities and positive activities for young people in low income neighborhoods:

> Lot of kids in poverty, they can't do nothing. They in the hood. They [drug dealers] walk up to you and your feet falling out your shoes. I'm telling you man, they go "We can make you a hundred bucks" and that sound real tempting.

4.1.4 | Sensing interpersonal negativity

Participants described sensing negativity as another form of stress and adversity. When negativity was described, it was in relation to people who are "closed-minded," "ignorant," or who have a "bad attitude," "hate on you," "talk down on others," "want to fight," or create "too much drama." Nadia explained, "they don't consider other people, they only consider their own problems, it's because they too stuck in their own bubble." She also expressed that she could relate to this negative attitude, because of seeing and going through so much: "We become that; you don't even realize that you're waking up with attitude or you snapping at this person."

4.1.5 | Lacking social connection and interaction

Victoria described negativity more bleakly, "it's like everybody's in a dark place," and related this to lacking social connection in the community, stating "I know for me it makes me feel uncomfortable, like unwelcome, if I walk somewhere and I speak to someone and they don't speak back." Teresa lamented that while her neighborhood looks nice, her neighbors do not interact or organize for a greater purpose: "It's horrible. Where's our neighborhood watch? Who's watching each other's back and when do we have a community meeting? It's chaos."

Others described a yearning for community beyond place and time. Shaun discussed how he felt connected to other young people throughout the city, yet experienced a sense of loss and grief for a time when the community looked out for each other's children. Dominique expressed a need for social connection that stretched to those most vulnerable, such as individuals with severe mental illness: "It's a lot of lost people out here and there's nobody for them. Like who is going to be for them, you know? We don't know what's going on with anybody."

4.1.6 | Lacking adequate community-based resources

Adversity for participants also presented as lacking adequate community resources. While many mentioned a variety of programs and services that they used and liked (e.g., disability, domestic violence, and substance abuse services), they felt that certain kinds of community resources were lacking, such as youth mentorship and recreational programs. There was a perception of loss of free after-school programming and space within parks, playgrounds, and schools. Moreover, community-based organizations and associations that brought residents

together to organize for neighborhood improvement and social connection were wanting. Some were also concerned about people experiencing homelessness, and the need for more shelter space, hot meals, and clothing. Many also felt that appropriate mental health services were lacking in the African American community. Brenda spoke about how social services were sometimes reactive rather than proactive. She highlighted the common and collective distrust of outsiders coming into the neighborhood to offer services only after a negative incident, like a homicide. She stated, "I think it should be more of a [regular] community thing."

4.1.7 | Identifying structural and systemic barriers and inequities

The discussion of inadequate community resources was tied to identifying structural and systemic barriers or inequities. Tiana made note of perceived inequities between different communities, due to the way government resources are allocated:

> 'Cause there's a lot of funding that the state has that they don't pour into the actual communities. But they will have the attractions around town. But it's like the same resources can be used for something that puts the school system or things that minority areas need that they don't have.

Naeem agreed, adding that he felt that resources and programs sometimes seemed to be "hidden" from those who may need them the most, with good programs located instead in wealthy communities: "Now we gotta try to sneak through they communities, and they looking at us strange, like we coming over there to look in they windows."

A few discussed the structural barriers related to health care and insurance, particularly the cracks that people fall through because they are either newly employed (on a probationary period), do not earn enough to cover insurance payments or medical costs, or just exceed household income limits for state insurance programs. Others spoke outright about classism, racism, and discrimination due to a criminal record, particularly in terms of inequitable wages and inability to obtain employment, or their perception of unfair or disrespectful treatment by their bosses, colleagues, or customers. For instance, Naeem mentioned unequal treatment by an employer: "if he gets $16, I want $16. Don't give me no $12 just 'cause I'm Black." Moreover, some identified other structural barriers such as a lack of affordable housing and living wage employment (e.g., "this used to be a family state where you could easily get a job, take care of the family"), and neighborhood gentrification (e.g., "everything's been turned into apartments").

4.2 | Coping with and healing from stress, adversity, and trauma

Study participants were asked questions related to what helps them get through hard days, times or challenges; how they heal; and what they envision for themselves and the community. Coping strategies were abundant and varied. Findings related to these strategies and ways of healing are presented at individual, family, collective, and structural levels.

4.2.1 | Individual-level coping and healing

At the individual level, identified categories include engaging in spiritual practices, practicing positivity and bettering oneself, activating self-efficacy and self-determination, and identifying trauma and its effects (as a step toward healing).

Engaging in spiritual practices

Spiritual practices were a significant aspect of participants' coping and healing. For some this meant reading the Bible, regular prayer or talking to God, being an active member of their church and church programs, ministering to others (helping or encouraging others), receiving pastoral care, and listening to Gospel music. These practices served to help participants calm their minds, cultivate gratitude, find spiritual guidance, and nurture a connection with a higher power. Elaine said, "my faith practice has made me understand that even through the shit there are still some blessings in there that I got to make sure that I look for." Dominique similarly stated, "the spiritual growth helps me have a really great day even when it's still a lot going on around me."

Practicing positivity and bettering oneself

Positivity and self-improvement were highly important to focus group members. Some of the coping strategies mentioned include daily affirmations, vision boards, visualization, gratitude practice, ceasing rumination, and other mental preparation to deal with the day and people in their lives. Bettering oneself was intertwined with positivity; this involved strategies like educating and challenging oneself, engaging in self-care practices that helped put them in a positive frame of mind, and staying focused on one's goals. Malcolm explained his perspective: "Think positive. First thing I do is to be blessed to wake up in the morning. The second thing is to focus on your main goals, not to think negative."

Activating self-efficacy and self-determination

This category was tied to positive thinking and bettering oneself, but reflected a sense of power and hope—an ability to accomplish goals. When asked about getting through hard times, Naeem responded, "pretty much I try to talk something into existence. You know, I own my own business so I try to talk something positive into my head to keep me from getting stressed out." Malcolm expressed, "some days it be rough, but you still stay powerful. You can't let nothing stop you." Nadia firmly believed, "it starts with self," and articulated how she activates self-determination: "If the situation arises where I'm interacting, then I have the opportunity to make the best out of it. That's within my power." Bridgette stated, "if you're willing to do it, then it's nothing that can get in your way. No matter what it is."

Identifying trauma and its effects

Participants recounted how they were able to recognize traumatic events in their lives and how it affected them, which led to some relief and personal growth. Shaun said, "I didn't realize how much I was going through. And from that point on, it gave me some relief. It gave me a breather." Some felt that identifying and talking about their trauma exposure helped them gain understanding and compassion for themselves, especially when it had resulted in some problematic behaviors (e.g., addiction, aggression). Odette explained:

> You know, as a kid, you either forget it or you bury it, you just don't want to think about it. And eventually it goes away. Well you think it go away, but you don't know until things come up that you go, wow, why this way, why would I do that?

Others talked about learning more about trauma through their jobs or certain programs, which helped them to feel less alone in their experiences and advanced their healing.

4.2.2 | Family-level coping and healing

At the family level, participants shared coping strategies such as spending time with children or grandchildren and socializing with family members. At times, however, coping meant limiting interactions (physically or emotionally)

with family and partners. The categories that emerged were being close and spending time with family, motivated by family/children, learning lessons from family, setting boundaries with family and learning to forgive.

Being close and spending time with family

This category included both immediate and extended family members. Some participants mentioned having a particularly close-knit family. During a lighthearted discussion about money buying happiness, Brenda stated, "no, I want my family, through thick and thin, even if I had to give all my money away." Some had mutual support with immediate and/or extended family members; they were available to each other to talk through problems or spend time together.

Odette shared about her close relationship with her daughters: "If they going through something with their boyfriends, or with they dad, or work, or some jealousy in they clique, we talk through stuff and it makes us feel better. That's how me and my girls roll—we talk." Some group members noted that family facilitated other coping activities, such as helping them "just get out of the house."

Motivated by family/children

Many participants agreed that responsibility to family was an important motivating factor not only to do well day-to-day, but to provide a positive sense of purpose when enduring stressors. This meant providing for their immediate families and helping extended family in times of need. Per Naeem, "to be honest, it's like I just get up hungry. My motivation is my kids, and to be a provider." Odette discussed her daughters' financial struggles and how she cannot let her grandchildren go without: "And so that's why I just thank God that I work so I can be able to help them." Other participants echoed the ideas of "pushing forward," "staying focused," and taking on challenges for the sake of their families.

Learning lessons from parents

These teachings served to provide a foundational coping skill and mode of healing based on intergenerational and cultural wisdom.

Victoria discussed how she was raised, how that affects her today, and what she tries to instill in her own children: "My mom always told me charity starts at home and spreads abroad. So the way that you carry yourself out there in public is the way that you carry yourself behind closed doors." Shaun agreed with Victoria: "I was taught, you know, once you leave out the house, you're representing somebody." Victoria added, in regards to social interaction in the neighborhood, "like I was always taught, if you're sitting on your porch and I'm a passerby, I'll speak. 'Hello, how you doing?' Because that's how I was raised." Nadia shared that she teaches her children, "you treat people the way we want to be treated because that was taught to me."

Setting boundaries with family

For some, limiting contact or content of discussion with family was key to coping and healing for many participants. Lawrence indicated that he keeps to himself rather than share his challenges with his family, to avoid having them "use it against me." Other group members agreed that they took precautions with certain family members to protect themselves emotionally. Though difficult to do, it promoted their own growth and healing by facilitating awareness of their own limits and ensuring that those limits were respected.

Learning to forgive

Elaine talked about the importance of setting limits while also forgiving her sister, "but forgiveness is different than tolerating, so that's what I have become more aware of. I still love my sister, but I don't have her as close emotionally as I used to." Forgiveness of partners and family members (and of self) was a part of growth and healing for many. Odette directly stated, "you gotta forgive. That was my thing—forgiving my ex-husband, and then myself. Because although he had hurt me, I did some hurtful things to him, too." Forgiveness was implicit in

Brenda's story of her relationship with her father: "I just lost my dad. Even though all my life I hated him, I wanted to kill him a couple of times because the shit he did. But then I bit my lip because he got real sick and I took care of him for the last 11 years." Though Brenda was both grieving the loss of her father and grappling with traumatic memories, she had taken steps to heal through forgiving and caring for her father in his last days.

4.2.3 | Collective and structural-level coping and healing

At the collective and structural level, the categories identified include seeking and practicing positive social connection, bonding with others, drawing on and envisioning community-based resources, addressing structural and systemic barriers and discrimination, and benefiting from the Work Matters program (a microcosm of healing self in community).

Seeking and practicing positive social connection

This category includes having people with whom they could talk things through, share hobbies or activities, "laugh and talk shit," and interact in a positive manner in their neighborhoods or other settings. Authentic interactions were desired, where "hello" and "how are you" felt sincere and genuine. Some participants spoke about socially connecting with "people that I can vibe with." According to Naeem, "good vibes is like people who on something positive, seeing things positive, doing things positive." Nadia explained how she had a "good positive circle," a team of people in her contact list who can help her get through challenges: "I try not to let stuff get under my skin. But for some reason, if it has, I reach out to certain people that I know for a fact that can bring me back and evaluate the situation with me." Dominique felt that while working on improving and loving oneself was paramount, spreading positive social connection was also needed: "So just surrounding ourselves with the ones who need to be uplifted, so hopefully it'll cause a chain reaction. So, you know, people would catch on to it."

Neighborhood block parties and barbecues were often mentioned as a means to get people together, and to have children playing together. Nadia made concerted efforts to be neighborly and helpful, and gave the example of giving out food to kids from the neighborhood who wander over when she is grilling outside. She explained, "because I'd rather them be playing and getting to know each other this way than to be fist fighting or hurling insults."

Odette desired, "open communication with the neighborhood," which she felt was a means to improve the neighborhood and increase safety for children. Shaun recounted how he felt safe and secure as a kid in his neighborhood because family members lived nearby and everybody in the neighborhood knew him. This meant that,

> if I needed it, if they got to shooting or the older kids got to fighting up there, I knew I was able to run into any one of these old people's cribs and knock on they door. And they'd tell me, "come on [mother's name]'s son, come on in here and I'm going to call your momma so she can come get you." We need to get back to that.

However, Malcolm discussed how the community was changing and coming together, and that there was not just violence all the time in his neighborhood as the media portrays: "So everybody got to get to know each other. You know what I'm saying, to know who their neighbors is and who around the corner is, who's this and who's that, so…That's what that is about right now."

Bonding with others

Though tied to positive social connection, this category entailed a deeper bond with others who share similar struggles and group identity, and who actively work together to heal. Shaun, 20 years old, gave two poignant

examples of informal social networks that serve to meet needs, problem solve, and collectively heal. First, he talked about healing from shared trauma through a collective form of bonding with peers in an extended social network:

> But I can remember last year around this time coming to Work Matters, I lost eight friends in like two months to gun violence. And I can remember every day for that whole entire time, like just being surrounded. It was a lot of times with strangers, friends and cousins, and we all were just kicking it. You know, we looked at each other. We all had different points of views on the situation. We might not like that person over there. I know I was kicking it with some dudes that I had fought a few years ago, but it was just like, this is here, this is the moment. You know, we gotta get past it. Squash it. Call it a day. You have to still learn how to connect with something else. Tethering with another mind will help you understand your own point of view.

The other example Shaun gave was an organically created daily social support system—a judgment-free group chat called "family" composed of about 20 people who "faithfully text each other every morning," talk through issues, and share their different perspectives. He shared how impactful this digital social platform has been: "Like it's done been some situations where, you know, a couple of suicidal things that happened in the group chat. And we were able to get them out of it. Like fully was like, got a text message the next morning. Like, 'y'all really saved me.'"

Drawing on and envisioning community-based resources

Participants mentioned many different types of programs they had used or were aware of throughout the city that they viewed as helpful resources. Some saw themselves as community resources, drawing from their own leadership skills and values that promote "putting yourself in other people's shoes," "treating others the way you want to be treated," and "paying it forward" to offer ministry, mentorship, and support to others. Korey talked about how he benefited from employment programs and felt it was important to "pay it forward," so he began helping his friends get jobs as well. He said it started with giving advice, but then, "I'm like, 'no, come with me.'" He added, "I try to help as many people as I can."

Shaun spoke about the value of local neighborhood-based programs, specifically a grassroots program co-founded by an African American couple from that neighborhood. He explained that people know to respect the neighborhood and not litter because of all the community effort that goes into beautifying, growing food, and other development projects in that area. Shaun felt the impact was great: "If you start applying so much positive, it has no choice but to rub off. It has no choice but to generate an everyday lifestyle for the kids."

Many spoke about the need for community centers and positive activities for children and youth, and mental health resources for everyone. Naeem felt that "good and positive" youth activities should be better advertised: "Then they'll see that, probably tell their parents, 'I wanna go to that center and see what's going on there, it looks like they have a lot of fun there.' Something like that'll probably help the community." Michael wanted to find ways for youth to channel their talents, skills, and intelligence. He indicated that it's the "smartest ones that be going in and out of jail all the time, but they just use it in the wrong way, see what I'm saying?"

Malcolm suggested that community-based mental health care services were needed: "I think they should have different therapists going like spread around different communities." He added that many do not have adequate transportation to get to appointments, and that the issues in the community need to be addressed on site and within the community:

> A lot of people need help, a lot of people need houses. You see all this stuff. So now it's like, hey, let's bring the fight to the community. We out here now, why we can't bring it to the community?…Bring it to the church hall too, you know what I'm saying?

Dominique similarly commented about mental health resources, "if people can go out, like these offices, especially the African American based ones, can go out in the community and just do free, like maybe a night, a week, or something, and just have a mental health night." She continued by suggesting that mental health stigma could be dispelled by having family members accompany and support African American elders, in particular, in utilizing community-based mental health resources. Kenneth felt that many problems in the community could be addressed with proper mental health care that addressed the traumas that people have lived through: "And if we can get to the bottom of what gets people to that point, then we can erase that situation."

Focus group members dreamed about their futures, in terms of themselves, their families, and the community. Notably, their plans often involved helping the community and working toward collective healing. Malcolm shared his dream: "I like to work around cars, have my own car business, and help out the community, like 'you wanna buy a car, then do this, do that,' stuff like that to help them out with." Dominique also had collective goals at heart, declaring that one of her biggest dreams was to own her own housing development for single moms and families and "to help men coming out of incarceration" with various resources. She added, "housing is a big, big deal to me, and we don't have a lot of it here for families or for men coming out of incarceration." Tiana's community-oriented goal was to be a "dope therapist" and counsel others like her: "I have a therapist like that and she grew up in some of the worst zip codes, and she can relate to so much…The psychology thing is a thing I'm wanting to pursue in school."

Addressing structural and systemic barriers and discrimination

Related to the renewal of community-based resources, focus group members also concerned themselves with addressing structural and systemic inequities as part of coping and healing within the community. This meant addressing the way resources were distributed, which often felt unfair, inequitable, and discriminatory. Some, like Teresa, noted the abandoned facilities that were no longer being used for community purposes and asserted that they should be re-opened or rebuilt: "Get those playgrounds back for those children. Build the playground back in the parks and have the seesaws and sliding boards and monkey bars in every community. And not just the park. Bring those things back that they took away." Brenda similarly noted a desire for public resources to be directed to community purposes:

> They keep on saying that the cost…They [children] used to go to parks in the winter time. You would go ice skating on the lagoon. And we used to go to [park names]. "Oh, we ain't got the funds for it." But they should bring stuff like that back.

Employment was another area where systemic and structural forces were seen as barriers to economic stability and community well-being. Michael wanted to bring living wage jobs back to the state: "Back in 1993, '94, I know this used to be like a family state where you could easily get a job, take care of the family, lots of warehouses or whatever." Derrick felt that discriminatory employment practices needed to change: "I think that some of the questions on your applications shouldn't be there." He added, about the interview process, "when I explain the prison part, the conversation goes down. It goes from what I'm good at to asking me what I went to prison for, how long you been in prison, what did you do in prison?"

Governmental assistance programs were perceived as a stepping stone; some contended that people should not feel entitled to use them, but many also felt that they were inadequate and caught people in situations where it was difficult to change one's economic circumstances. Elaine, Derrick, and Brenda discussed changes that they believed needed to be made due to lack of eligibility for Medicaid, the state's health insurance program and household income caps, and the exorbitant cost of private insurance. They felt that people should not be forced to delay needed medical care that they cannot afford, or feel compelled to work fewer hours to retain health insurance. Malcolm spoke about his elderly father who worked and was getting minimal SNAP benefits through the

state, suggesting that people needed more to meet their basic needs: "Why they can't just keep paying everybody $200, $300, whatever? People gotta eat."

Benefiting from the Work Matters program

Remarkably, many of the elements of coping and healing that participants discussed, at all levels, were found when discussing the benefits of the Work Matters program. The program, staffed by African American and Latinx employees, represented a microcosm of healing self in community; this was a place where participants could learn and grow within an authentic community support system, and where they felt empowered to spread healing beyond the walls of the program. Participants spoke not just about learning soft job skills or finding employment, but about receiving trauma-informed, holistic, community-oriented services. Focus group members expressed that the program helped them become more confident, assertive, patient, productive, and self-aware, and felt that staff were like friends and family members to them.

Some talked about being in a dark place when they first arrived to the program. Teresa said that as she walked through the building, the staff greeted and acknowledged her with such genuine warmth and care, stating "they just was so, so full of life to give somebody else and not knowing they're giving me a darn thing. But they gave it to me, and I was like, my hair just went back." Tiana mentioned that she came into the program with a lot of stress and doubt, but found a source of greater healing than she could have imagined: "There was a lot of things mentally that I didn't really know about myself that I learned. And with each [staff person] I've had my own personal experience to where I've gotten more help from them than people I know."

Beyond personal growth, the program provided authentic social support and contributed to social cohesion and a sense of collective efficacy. Odette asserted, "they not doing this just for the paycheck, they really, really care." Naeem stated, "I like the program because they've really got the support system. You don't get that in other job places." Several used the word "hope" in describing what the program offered. According to Shaun, "Work Matters would be my real-world version of the Bible. They give the actual hope, that word." Nadia summed up how the program served as a source of hope and healing for individuals and the community:

> A lot of people in the community who come through these doors get the help and stuff and become a better them. And go out and execute this and be a better part of society. So for me, it's a program that gives so many hope…No matter what you need, what you here for, you walk out with better self-awareness. More positive. Better connections and ties with different people. It's like they offer so much in the simplest ways.

Many expressed that they wished more people would have access to Work Matters or that more programs would replicate their model. Teresa said, "I just want to share them with everybody." When asked what would help the community heal, Elaine explicitly responded, "organizations like this." She added that "a lot of the other organizations put band aids on, where I can really agree and know that this organization supports healing that wound."

4.3 | Mutual process of healing self and healing the community

The multiple levels of categories related to coping and healing from stress, adversity, and trauma, and the associations between them, began to reveal a theory of a mutual process of healing self and healing the community; healing occurred through intrapersonal, interpersonal, and structural change (see Figure 1). These different levels of change occur within the individual (intrapersonal), through family and social networks (interpersonal), and within a broader collective, such as the neighborhood or larger community, where structural healing processes may begin to occur. The healing process was bidirectional in nature, in the sense that healing self means to also work on

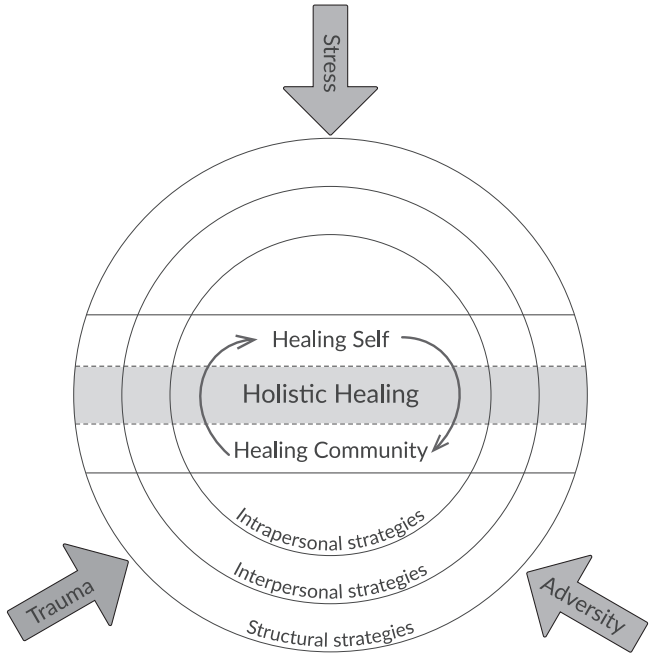

FIGURE 1 A mutual process of healing self and healing the community

healing the community, and healing the community was not possible without working to heal self; neither was sufficient without the other.

5 | DISCUSSION

This study provides insight into the socioecological context of trauma and the holistic processes that foster resilience, recovery, and healing. Trauma exposure, while experienced uniquely at the individual level, is often collective in nature, particularly when affecting communities of color. Therefore, concurrent change at individual, family, collective, and structural levels are needed to promote healing. These changes tend to be mutually reinforcing, and healing is incomplete without attention to each level of a person's social ecology. The theory of mutual healing of self and healing of community presents an expanded understanding of healing as a complex, multidimensional process that focuses on all aspects of a person's lived experience. The Work Matters program served as a microcosm of this bidirectional healing, by cultivating hope, social ties, a sense of belonging, and a sense of self-efficacy and collective efficacy that focus group members sought to spread throughout the community. This program provided a concrete representation of how mutual healing of self and community works.

This research offers several key insights and implications. First, findings highlight the potential benefits for trauma survivors of identifying traumatic experiences and associated symptoms within both individual and community levels. Doing so served as a critical step for participants to better understand themselves and the actions and attitudes of those around them. It also helped illuminate how trauma impacts health and well-being. This was true for Tiana, who reflected on how her own trauma affected her, but also how it caused many of those around her to feel "numb." For some, as in Derrick's case, trauma is experienced not only as a victim or bystander, but also as a perpetrator, which may have been a result of previous, unresolved trauma and ongoing risks to his health and safety. This finding suggests that trauma-informed care should be embedded within all community-based services and programs (Mersky et al., 2019; Levenson, 2017).

This study also revealed the importance of attending to multiple forms of stress, adversity, and trauma including historical, collective, and intergenerational trauma along with race and poverty related stressors. Trauma-informed care, and mental health care generally, have focused largely on coping and healing from individual and family level adversity; however, the current study demonstrates that individual and family-centered approaches to address traumatic stress should be broadened to include a person's collective experiences and healing modalities (Ginwright, 2018). While many spoke of prayer or family time, for instance, several participants pointed to the work they do or dream of doing to help others in the community, like creating more resources for young people to socialize and occupy their time in prosocial ways. The findings point to how healing of self happens within the context of community, when collective stress, adversity, and trauma are simultaneously acknowledged.

This research emphasizes the importance of mental health care that is accessible and aligned with culture and context. This means that mental health care and resources should be strengths-based versus deficit-oriented, acknowledging the strengths and resilience of the individual and family, and of the community and/or culture. For example, findings highlight the value of using an Afrocentric approach when practicing with African American clients, families, or communities (Brice & McLane-Davison, 2020; Johnson & Carter, 2019), or a healing-centered approach more generally, which takes into account both strengths and adversities at all levels of a person's ecology (Ginwright, 2018). Practitioners must also be attuned to structural level inequality (e.g., redlining, racial profiling, health disparities), historical and ongoing collective trauma (e.g., disparate police brutality toward people of color), environmental context (e.g., community violence concerns), and the individual, cultural, and collective means of coping and healing.

Results of this study also support recommendations specific to working with individuals and communities that identify as African American and have shared socioeconomic backgrounds. As suggested by Tiana and Dominique, the training and hiring of African American mental health professionals is indicated (Cabral & Smith, 2011), as is the need for mental health resources located within African American or low-income neighborhoods. Faith-based mental health interventions are also indicated (Hays & Aranda, 2016), and mental health resources could be colocated within culturally relevant spaces, such as church halls (as Malcolm advised). Additionally, the results suggest working toward reducing stigma and raising awareness about mental health in African American communities (Ward et al., 2013), potentially using family and church-based supports to help normalize the use of mental health resources (Motley & Banks, 2018).

Another implication of this research is the need for certain types of local programs or interventions that may be lacking in some communities. According to many participants, this includes community-based programs and mentorship for youth as a means to prevent victimization, promote peer support, and support youth employment. Also important are programs or initiatives that build social cohesion and collective efficacy (Driscoll et al., 2015; Johns et al., 2012), such as grassroots neighborhood associations and organizations that provide opportunities for residents to come together, organize, and develop their neighborhoods into vibrant, safe spaces (Rice et al., 2016). The facilitation of natural support networks (i.e., friend or kinship networks) that promote positive social connection and bonding is also key (Morenoff et al., 2001); for example, youth or community-led initiatives that create or strengthen safe, welcoming neighborhood and digital spaces. Shawn spoke eloquently about the innovative ways that he and his friends use digital platforms to create connection, solidarity, and mutual aid. Finally, practitioners and community residents can work together to advocate for equitable distribution of resources (e.g., reopening or repurposing public facilities in neighborhoods where they are lacking) and dismantling of structural barriers and discriminatory practices (e.g., working to end racial profiling and other discriminatory criminal justice policies and practices) is an essential part of the collective healing framework.

5.1 | Future research

Future research should explore the possibility of bidirectional healing processes, concerning both the individual and the collective. In-depth qualitative interviews with individuals related to this process may be a means of

exploring this phenomenon in greater detail. Given that the Work Matters program was perceived by participants as a site of healing of self and community, a better understanding of the program model and elements would serve as a means to enhance and replicate the benefits of their work. In addition, further research should examine social cohesion and collective efficacy as a means of coping and promoting resilience, trauma recovery, and healing. Translational research is needed to help bring this evidence around social support, social cohesion, and collective efficacy into practice in the community and within mental health care services. Additionally, coping and healing specifically among urban-dwelling White people with low incomes appears to be largely unexplored and may represent a needed area of future research.

5.2 | Limitations

The goal of this research was to examine experiences of adversity, coping and healing, with greater emphasis on understanding healing processes. Therefore, the authors did not address all risks or potential negative outcomes related to participants' adverse experiences. This study is limited by sampling procedures that may have attracted participants with a particular viewpoint; this selection bias may have led to over-valuing of the Work Matters program, for instance. All participants were also enrolled in a larger study in which they received a trauma-focused screening, intervention, and referral to treatment (if desired), and thus may have been more attuned to trauma-informed services and mental health support. This study's results are not generalizable to the population at large; however, the findings are potentially transferable to comparable populations.

5.3 | Conclusions

This research compels us to recognize that recovery and healing from stress, adversity, and trauma are both individual and collective experiences, and that mutual healing of self and of community is a bidirectional and cooccurring process. As individuals work toward healing within their social and community milieu, the community grows and heals by virtue of the richness the individual begins to uncover and the "positivity" they are able to spread within the community. As the community grows and heals, the individuals within it benefit, enjoying more opportunities for growth and healing, especially as structural violence and inequities diminish. The results of this study indicate a need for peer-led, community-engaged initiatives and holistic, trauma-informed, healing-centered practices. Findings support policy and practice that are strengths-based, culturally responsive, and context relevant, and that serve to dismantle harmful structural and systemic conditions (e.g., race and poverty related stressors such as resource inequity and discrimination). While healing may always be a work in progress, individually and collectively, this expanded understanding of the healing process offers a clearer path forward for community practice and policy advocacy.

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CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

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Research data are not shared.

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