Front-line Perspectives: Conceptualizations of Trauma, Adversity, Resilience, and Community and Social Support

by

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Dr. Athena Madan [signature on file]
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Abstract

This qualitative graduate-level study examines front-line community and social service professionals’ conceptualizations of resilience and the role of community and social support among survivors of trauma or adversity and individuals at-risk. A systematic review of recent literature on resilience and community and social support was employed to inform analysis of experiential data generated through in-depth interviews with ten community and social service professionals in central Ontario. Based on the hybrid thematic analysis of interview data, five themes were identified to illustrate front-line professionals’ conceptualizations of: i) resilience as a three-part construct; ii) secondary conceptual considerations; iii) the continuum of risk and protection; iv) community and social support; and, v) service design and approach considerations related to trauma-informed strengths-based approaches. Subsequent conclusions and recommendations regarding practical conceptualizations of resilience, the role of community and social support, and the incorporation of trauma-informed, resilience-building strengths-based strategies within community and social services are then presented.

Keywords: trauma; adversity; resilience; survivors; individuals at-risk; community support; social support; community and social services; front-line professionals; trauma-informed; strengths-based; multidisciplinary; interdisciplinary.
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Dedicated to my mom, Casey Catton – the foundation and rock from which I have built upon, to whom I am forever grateful for your resilience, love, and inspiration.

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Disclosure

No actual conflict of interest exists in the current study. During course-based graduate studies, the ethical review, and data collection phase of this study, the principal investigator served as the Board Secretary, Vice Chair, and Chair of the Board of Directors for the Elizabeth Fry Society of Simcoe County. Due to personal health circumstances, the principal investigator was forced to resign from this role during the analysis phase of the study. This information is disclosed for the sake of transparency to address any potential perceived conflict of interest and does not reflect any affiliation with this agency or the involvement of any of its employees or volunteers.
Glossary

The following key terms are central to this thesis and have been defined for the sake of clarity, consistency, and comprehension. However, these definitions are purposefully broad to enable diverse interpretations and applications across disciplinary boundaries, given the nature, purpose, and scope of this thesis as a qualitative interdisciplinary research study. For more detailed definitions specific to a particular discipline, author, and/or study referenced within this thesis, please refer to the associated references.

**Trauma:** Any event or experience subjectively perceived by an individual as being deeply distressing, disturbing, and involving a high level of acute or chronic stress that places inordinate demands on coping and adaptation, often resulting in physical or psychological injury and/or negatively impacting psychosocial wellbeing.

**Adversity:** Any event or experience subjectively perceived by an individual as being acutely or chronically stressful that places inordinate demands on coping and adaptation, often resulting in physical or psychological stress-related symptomology and/or negatively impacting psychosocial wellbeing.

**Resilience:** The capacity to respond to, cope with, and adapt following experiences of trauma or adversity by leveraging and/or building on existing skills, strengths, and/or resources in a manner that supports psychosocial wellbeing and mental health.

**Survivors:** Any individual who has self-identified as having been exposed to and/or affected by a traumatic event or experience.
Individuals at-risk: Any individual who has self-identified as having been exposed to and/or affected by trauma or adversity, whereby this prior exposure, its short- and/or long-term impacts, and/or its context may predispose further exposure to recurrent trauma or ongoing adversity.

Community and social services: Human services delivered by governmental, private, for-profit, and/or non-profit organizations intended to support the wellbeing of the community and its individual members, typically through the provision of practical and/or psychosocial support.

Community support: Formal or informal support provided by members, groups, organizations, and institutions within an individuals’ community as part of their distal social network, including through schools, workplaces, religious institutions, community and social services, and other community groups.

Social support: Formal or informal support provided by members of an individuals’ proximal social network, including family, friends, peers, colleagues, and professionals with whom they have a therapeutic relationship.

Trauma-informed: Programs, services, and clinical approaches or interventions that do not necessarily provide formal counselling or therapy for trauma or related mental health sequelae, yet are informed by best practices for the treatment of trauma-related mental health symptomology and psychosocial difficulties, thereby: i) recognizing a diverse range of potentially traumatic experiences and their highly variable impacts on mental health and psychosocial wellbeing; ii) aiming to foster resilience through client-centred approaches that emphasize self-determination, skill-building, and sense of agency, control, safety, and self-efficacy; iii) requiring trained and skilled professionals and practitioners who competently
demonstrate their understanding of trauma and its impacts within both clinical practice and service design.

**Strengths-based**: Programs, services, and clinical approaches or interventions aiming to foster resilience that are informed by a paradigm that emphasizes and leverages individuals’ strengths, assets, and resources, rather than deficits, to enable them to respond to complex problems or challenges.

**Multidisciplinary**: Cross-disciplinary collaboration, wherein researchers, scholars, professionals, departments, and/or organizations from various disciplinary backgrounds collaborate to combine and share knowledge and practices associated with each discipline in a manner that enables co-operation between disciplinary silos, often with the intent of addressing or responding to complex problems or phenomena.

**Interdisciplinary**: Cross-disciplinary integration, wherein researchers, scholars, professionals, departments, and/or organizations from various disciplinary backgrounds collaborate to synthesize knowledge and practices associated with each discipline in a manner that results in interrelationships between disciplinary silos that enables holistic interpretations and approaches, often with the intent of addressing or responding to complex problems or phenomena.
Personal Equipoise

To articulate my own point of departure in relation to the research topic as the principal investigator, it is necessary to reflect on my childhood experiences and longstanding interest in survivorship and the human condition. Born to two Caucasian working-class parents in a rural town north of Sudbury, Ontario, my early childhood was far from adverse. Both my parents had histories of childhood trauma and adversity but were committed to breaking the intergenerational cycle of trauma and abuse they experienced. They were attentive, caring parents who provided my younger brother and I with a warm and stable upbringing in a middle-class home. I was a naturally curious child with an interest in fairy tales and superheroes, and often asked about my family history, my parents’ childhoods, and other families. Eventually, my early childhood interest in fairy tales and heroes shifted to real-world stories of survival and heroics–how ordinary people could overcome extraordinary events or circumstances.

Aside from uneventful tonsillectomies, my brother's broken leg, and ongoing bullying in elementary school that led to two years of home-schooling at my persistent persuasion, I can recall few unhappy times in my childhood. However, at the age of thirteen, my life as I knew it dissolved. Ongoing intermittent criminal harassment toward my family related to an interpersonal conflict from my father's early adult life precipitated his acute paranoid psychosis and eventual suicide. The criminal harassment persisted following my father’s suicide, resulting in a police-assisted move from our home town. The death of my father followed by my family’s subsequent relocation served as a key turning point in my life. These traumas initiated a cascade of additional interpersonal traumas and social and economic adversity that persisted throughout
my adolescence and young adulthood. Thrown into relative poverty and isolation, I engaged in self-medication through substance use and risk-taking behaviour, and encountered two sexual assaults in the span of a year. By the end of high school, I struggled with a wide array of mysterious physical health complaints and was subsequently diagnosed with a rare autoimmune disease and heritable connective tissue disorder soon after beginning my undergraduate degree.

My interest in how ordinary people could overcome extraordinary events or circumstances expanded following my own experiences and having observed my immediate and extended family members’ unique and varied responses to our own trauma. More specifically, my interest shifted toward how some go on to thrive while others struggle to survive in the aftermath of trauma or adversity, underpinned by existential questions of how and why I survived and what my future would be versus what could have been. Yet by the end of my undergraduate degree, my interest in how some survive while others thrive following trauma or adversity expanded even further. Consequently, I was left with questions about how some lives remain untouched by trauma or adversity, yet it remains almost unescapable for others; how interpersonal relationships can be the source of both an enormous amount of trauma and an abundance of support; and how and where these supportive relationships come from.

With heightened interest in resilience and the role of community and social support, I pursued my graduate degree only to encounter additional health complications, failed treatment regimens, and disease exacerbations. I enrolled in a Master of Arts in Interdisciplinary Studies degree through Royal Roads University with the intention of completing my thesis on resilience among survivors of trauma or adversity and individuals at-risk. Based on the body of literature
on resilience, trauma and adversity, complex systems, and social-ecological determinants of wellbeing that I encountered during my studies, in addition to my own experiences of trauma and adversity, I was intrigued as to how professionals conceptualize resilience and the role of community and social support. In turn, I sought to leverage this body of literature along with my own connections to professionals who frequently interact with survivors or individuals at-risk, with the hope of capturing a more practical and applied understanding of trauma and adversity, resilience, and community and social support.
Chapter 1 – Introduction

How do ordinary people survive extraordinary circumstances? Why do some people struggle to survive while others go on to thrive? Answers to these questions remain elusive and complex despite the overwhelming body of psychological research and literature on trauma, adversity, and unfavourable mental health outcomes. The fields of psychology, social work, and human services have been marked by a dramatic shift away from a limited focus on risk factors and the amelioration of trauma-related mental health sequelae, toward a broader focus on leveraging existing strengths, capacities, and resources, positive psychology, and positive mental health promotion (Garmezy, 1987; Rutter, 2012). The origins of the multidisciplinary concept of resilience lie within this paradigm shift away from overly negative conceptualizations of trauma, adversity, and related mental health distress.

Current research on resilience has continued to expand, largely focusing on the theoretical conceptualization and empirical operationalization of resilience with relatively limited attention to implications for prevention or intervention initiatives, despite the need for multidisciplinary resilience-building interventions (Harvey, 2007; Miller, 2003; Rutter, 2013; Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014; Walsh, 2007; Wolkow & Ferguson, 2001). Numerous resilience-related research initiatives and interventions have been developed within psychology and social work; however, many are focused solely on child and adolescent development, and few focus on applications within existing community-based mental health initiatives targeting individuals across the life course, despite the potential for trauma, adversity, and the need to foster resilience beyond childhood (Garmezy, 1991; Harvey, 2007;
Miller, 2003; Rutter, 1987, 2006, 2013; Walsh, 2007; Wolkow & Ferguson, 2001; Zimmerman, 2013). Given the need for further research on the applicability of resilience-building approaches in community and social services and limited attention to front-line professionals’ practical conceptualization and application of resilience concepts, this qualitative graduate-level study examines front-line professionals’ conceptualizations of resilience and the role of community and social support in order to develop a conceptual framework for clinical practice, research, and program or policy development to inform resilience-building approaches within community and social services. The purpose of this study is two-fold: i) to explore the compatibility of existing theoretical knowledge about resilience with community and social service professionals’ practical understanding and application of resilience and the role of community and social support; and, ii) to explore the role of community and social services in fostering resilience among survivors of trauma or adversity and individuals at-risk.

This study began with a systematic review of recent literature on resilience and the role of community and social support. Findings from the systematic review subsequently informed the thematic analysis of individual in-depth interviews with ten community and social service professionals in central Ontario. Based on the thematic analysis of in-depth interview data, five themes regarding resilience as a three-part construct, secondary conceptual considerations, the continuum of risk and protection, community and social support, and service and approach considerations were identified to address the following research questions:

1) How is resilience conceptualized among community and social service professionals?
2) What role do community and social support play in fostering resilience?
3) How can community and social services foster resilience among survivors of trauma or adversity and individuals at-risk?

First, this thesis introduces the study with a summary of seminal research on resilience prior to the presentation of findings from the systematic review of more recent research on resilience, community support, and social support. Qualitative methods that guided data collection and analysis procedures are then described in detail, followed by the presentation of results from the thematic analysis of in-depth interviews with community and social service professionals. Following a discussion of consistency with prior research and methodological limitations, conclusions regarding participants’ conceptualizations of resilience and the role of community and social support are presented along with recommendations to enhance community and social services by incorporating trauma-informed, strengths-based resilience-building strategies. By capturing front-line perspectives, this study offers an enhanced understanding of how: i) resilience is practically understood; ii) personal, social, contextual, and intersectional conditions that support resilience; and, iii) recommendations for the application of strengths-based resilience-building approaches that support psychosocial wellbeing among survivors of trauma or adversity and individuals at-risk.

**Epistemological & Theoretical Orientation**

A contextualist methodological orientation was adopted for the analysis within this study (Braun & Clarke, 2006). This orientation affords the flexibility to blend essentialist and constructionist perspectives, and “acknowledge[s] the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while
Front-line perspectives retaining focus on the material and other limits of reality” (Braun & Clarke, 2006, p. 86). Within this contextualist orientation, an essentialist perspective to interpret semantic themes regarding lived experiences and subjective meanings has been combined with a constructionist perspective to identify latent themes stemming from the social contexts in which subjective meanings and experiences are embedded (Braun & Clarke, 2006).

The analysis within this study corresponds with the notion of forcing grounded theorizing (Richardson & Kramer, 2006) through the use of a hybridized coding paradigm that deductively links existing theories and concepts to experiential participant data, while inductively developing and refining themes and patterns occurring within the data itself (Fereday & Muir-Cochrane, 2006). This approach aligns with Braun and Clarke’s criticism that the notion of “emerging themes” (Taylor & Ussher, 2001, p. 85, as cited in Braun & Clarke, 2006, p. 85) in thematic analysis denies the active role of investigators, and erroneously implies that themes “reside” in the data and will “emerge” if we look hard enough (Ely, Vinz, Down, & Anzul, 1997, pp. 205-206, as cited in Braun & Clarke, 2006, p. 85), thereby ignoring the principal investigator’s mental labour within the analysis. Likewise, Coffey and Atkinson (1996, as cited in Richardson & Kramer, 2006) argued that existing theory and concepts can serve as valuable tools in the creative development of ideas and linking data-based trends with external knowledge, where their discussion of “associating data with ideas” (1996, p. 155, as cited in Richardson & Kramer, 2006, p. 500) through abduction acknowledges investigators’ intellectual and imaginative cognitive work parallel to the task of data management in analysis and theory development. In turn, salient ideas and trends cannot be discovered by scrutinizing the data independent from
external knowledge within prior research or the mind of the principal investigator, because these ideas and trends do not reside in a vacuum isolated from our cognition and mental labour.

**Background Literature**

Although the ground-breaking study on the adult health impacts of childhood exposure to adverse childhood experiences (ACEs) was excluded from the systematic review of more recent literature on resilience and community and social support due to its date of publication and a lack of an explicit focus on resilience, these findings exemplify the negative impacts of childhood exposure to trauma or adversity across the life course and provide a foundational understanding of trauma and adversity within more recent resilience research. Using a rigorous analysis of a large, representative sample of over eight thousand adults that controlled for demographic factors, Felitti and colleagues’ (1998) assessed the relationship between exposure to seven forms of ACEs, adult health risk behaviours and risk factors, and health status/disease. Their findings demonstrated the strong and cumulative impact of exposure to ACEs on adult health and wellbeing. Specifically, they noted that individuals exposed to four or more ACEs faced a dramatically increased risk of alcoholism, substance use, depression, attempted suicide, poor health or disease, and/or premature death (Felitti, et al., 1998).

Likewise, much of the seminal research on resilience was excluded from the systematic review of more recent literature as a result of publication dates and/or the lack of an explicit focus on community or social support. However, this body of work warrants a brief summary to situate findings from more recent research. Regarded as the founder of resilience research, Norman Garmezy (1987) described the increasing progression of negative outcomes in the
presence of cumulative risk factors. More specifically, he noted that the likelihood of unfavourable mental health outcomes was not appreciably greater among children exposed to a single risk factor compared to risk-free children, yet exposure to two or more risk factors resulted in a four-fold increase in the likelihood of psychiatric disorder. Additionally, he identified six familial risk factors correlated with childhood psychiatric disorders, including severe marital stress, low social status, overcrowding or large family size, paternal criminality, maternal psychiatric disorders, and foster care admission and placements. However, Garmezy (1987, 1991) also identified three categories of protective factors, including temperament and personality dispositions, a supportive family milieu marked by warmth, cohesion, and stability, and external support systems that encourage and reinforce healthy coping and positive values.

Separately, Emmy Werner (1995, 1996; Werner & Johnson, 2004) identified a similar core of protective factors associated with resilience among children using a multi-ethnic sample of 698 children born in 1955 followed until the age of thirty-two through the foundational Kauai Longitudinal Study. Almost a third of this sample were considered high-risk, where two thirds of children who encountered four or more risk factors before age two developed cognitive or behavioural problems by age ten, or had criminal records, mental health challenges, or pregnancy by age eighteen, while one in six faced at least two additional challenges as adults. However, the remaining third assumed a contrasting trajectory characterized by resilience, competence, and normative functioning and development (Werner, 1995, 1996). Werner (1996) subsequently identified five clusters of protective factors, including temperamental characteristics, personal skills and values, parental characteristics and caregiving styles, external sources of support, and
the opening of opportunities at key developmental and life course turning points. According to Werner (1995, 1996; Werner & Johnson, 2004), positive temperament elicits positive responses from competent caregivers that promote autonomy, maturity, adaptive coping skills, scholastic competence, social support, and enhanced risk-appraisal and support-seeking behaviour through early and middle childhood, and sense of self-efficacy, affect-regulation, and internal locus of control through early to middle adulthood. In turn, positive temperament and cognitive and social competence enabled children to seek out external sources of support and construct social environments that reinforced their competencies and were more conducive to fulfilling their developmental needs. Furthermore, major life transitions in early adulthood served as critical turning points for the opening of opportunities or second chances that provided an escape from adversity and opportunities to reinforce and exercise competencies that foster self-esteem, self-efficacy, and supportive connections with others (Werner, 1995, 1996; Werner & Johnson, 2004).

Last but certainly not least, Michael Rutter (1987, 1999) proposed four mediating mechanisms for resilience, including: i) the reduction of risk impact through alteration of the risk or level of exposure; ii) the reduction of negative chain reactions and the promotion of positive chain reactions and neutralizing experiences; iii) the promotion of self-esteem and self-efficacy through secure and supportive personal relationships and task accomplishment; and, iv) the opening of opportunities at key life turning points. Notably, Rutter (1987, 2006, 2012, 2013) combined extensive findings illustrating the potential for steeling effects of prior stress exposure, where successful exposure, coping, and engagement with prior risks or challenges, rather than
the avoidance of risk, can strengthen resistance to later exposure. Thus, protection can actually stem from variables that are typically a source of risk, as exemplified by immunization as a controlled exposure to infectious pathogens, the sickle cell phenomenon that induces disease yet offers immunity to malaria, and adoption or non-maternal care as protective factors in the presence of abuse, neglect, or poor parental competence, yet offering no protection and even some degree of risk for children from low-risk backgrounds (Rutter, 1987, 2006, 2012, 2013).

In his later work, Rutter (2012, 2013) further identified various mental features associated with resilience including planning, self-reflection, self-control, sense of agency, determination, identity or self-concept, self-confidence, and self-efficacy, wherein these mental features influence the cognitive appraisal of experiences and coping beyond temperament or personality dispositions. Likewise, he also highlighted the role of gene-environment (GxE) interactions and biological influences on resilience, arguing that genes are not in and of themselves predisposing risk factors that constitute liability for unfavourable mental health outcomes, and instead reflect susceptibility or vulnerability to environmental influences that interact to produce specific psychopathologies, where genes have little to no effect on psychopathology in the absence of environmental risk factors (Rutter, 2006, 2012, 2013). Finally, Rutter (2006, 2012, 2013) advocated for a life course perspective of resilience that accounts for both the behavioural and neural effects of later experiences in adulthood, and acknowledges the potential for delayed recovery or resilience attributable to turning point effects in adult life, where protection may be derived from circumstances occurring long after childhood exposure to trauma or adversity. Overall, Rutter (1987, 1999, 2006, 2012, 2013) concluded that resilience is an interactive process
that evolves over the life course and involves dynamic features that produce enormous heterogeneity in individual outcomes as a result of continuous context-specific and individually-variable interactions between risk and protective processes and personal and environmental characteristics, wherein singular factors exert relatively small effects compared to the cumulative impact of interactions. Much of this seminal research is referenced throughout more recent research on resilience and provides a foundation for this thesis and the systematic literature review.
Chapter 2 – Literature Review

Literature Review Procedure

Database Searches

The systematic review of more recent literature was conducted to address the question of: *what does recent research say about resilience in relation to trauma or adversity and the role of community and social support?* Two search phrases (see Table 1) were used to retrieve 944 initial results across five databases (see Table 2). Results were limited to articles published between 2007 and 2017 due to the breadth of results retrieved using the search phrases.

Table 1

*Database search phrases*

<table>
<thead>
<tr>
<th>Search Phrase</th>
<th>Results*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resilien* AND “trauma” OR “adversity” AND “social support”</td>
<td>440</td>
</tr>
<tr>
<td>Resilien* AND “trauma” OR “adversity” AND “community support”</td>
<td>345</td>
</tr>
<tr>
<td>Search phrase duplicates</td>
<td>315</td>
</tr>
<tr>
<td><strong>TOTAL</strong>*</td>
<td><strong>470</strong></td>
</tr>
</tbody>
</table>

*Result totals have been corrected for duplicate articles across databases; duplicate articles resulting from both search phrases have been presented and subtracted.

Table 2

*Databases and filters*

<table>
<thead>
<tr>
<th>Database</th>
<th>Search Filters</th>
</tr>
</thead>
<tbody>
<tr>
<td>psycARTICLES</td>
<td>Keywords; full-text; human subjects; published after 2007.*</td>
</tr>
<tr>
<td>psycINFO</td>
<td>Keywords; full-text; human subjects; published after 2007.</td>
</tr>
<tr>
<td>JSTOR</td>
<td>Psychology and/or social work disciplines; full-text; published after 2007.</td>
</tr>
<tr>
<td>Scopus</td>
<td>Keywords; psychology and/or social sciences disciplines; full-text; published after 2007.</td>
</tr>
<tr>
<td>PILOTS</td>
<td>Subject headings; full-text; published after 2007.</td>
</tr>
</tbody>
</table>
Abstract Sift

The titles and abstracts of 470 articles retrieved via the database searches were then reviewed and filtered for inclusion (see Table 3) based on Cochrane systematic review guidelines (Hannes, 2011) using Butler, Hodgkinson, Holmes, and Marshall’s (2004, July, p. 48) Rapid Evidence Quality Assessment Tool. Given the explicit focus on psychological or psychosocial resilience, article abstracts focused on biological, physiological, or environmental resilience, or examining other determinants of resilience without explicit attention to community and social support were excluded as they are beyond the scope of this review. Article abstracts focused on related concepts such as post-traumatic growth, dispositional optimism, and psychological hardiness were excluded due to variable theoretical origins and conceptual or operational distinctions (Bonnano, Romero, & Klein, 2015; Goodman, 2015; Ungar, Ghazinour, & Richter, 2013). Finally, article abstracts not specific to first-hand experiences of trauma or adversity, such as those related to secondary trauma (e.g., vicarious or intergenerational trauma), and vicarious

Table 3
Abstract sift criteria

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Total (n = 470)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written in English.</td>
<td>n = 468</td>
</tr>
<tr>
<td>Full-publication within the last ten years (2007-2017).</td>
<td>n = 460</td>
</tr>
<tr>
<td>Explicitly focused on the phenomenon or construct of resilience within psychology, social work, and/or the social sciences.</td>
<td>n = 238</td>
</tr>
<tr>
<td>Discussed the role of community and social support as variables of interest and/or potential determinants of resilience.</td>
<td>n = 63</td>
</tr>
<tr>
<td>Specific to first-hand experiences of trauma or adversity (e.g., survivors of trauma and/or individuals at-risk).</td>
<td>n = 51</td>
</tr>
</tbody>
</table>
resilience, given that resilience and the impact of community and social support in relation to indirect experiences may differ from that of first-hand experiences due to the potential impact of additional relational or contextual variables (e.g., occupational versus personal roles; relation, duration, and/or nature of exposure to the primary individual).

**Article Ranking**

Fifty-one abstracts were selected for inclusion, including: five longitudinal studies; five practice or intervention approaches; five intervention model evaluation studies; three conceptual models/frameworks; three literature reviews; two ethnographic studies; two natural laboratory studies; two participatory action/community-based studies; two dissertations; two editorial commentary articles; eighteen quantitative studies using various methodologies not otherwise specified; and two qualitative studies using various methodologies not otherwise specified. All articles were published in peer-reviewed journals, excluding the two dissertations. The fifty-one articles selected for inclusion were scored according to quality indicators (QIs) adapted from Hannes’ (2011) guidelines for Cochrane systematic reviews and Butler and colleagues’ (2004, July, p. 48) Rapid Evidence Quality Assessment Tool to assess the dimensions of: i) truth value or credibility; ii) applicability or generalizability and external validity; iii) consistency or reliability and dependability; and, iv) neutrality or objectivity and confirmability. QIs across all dimensions were averaged to produce a quality factor (QF) score for each article, with lower QF scores reflecting higher quality articles and higher QF scores reflecting lower quality articles. Possible QF scores ranged from 1.0 to 4.0, with actual QF scores assigned to articles ranging from 1.2 to 3.7. Based on QF scores, articles were categorized as providing strong (n = 15),
acceptable (n = 33), weak (n = 2), or unreliable (n = 1) findings (see Table 4). Due to the breadth of the articles selected for inclusion, only articles scored as presenting strong findings (QF score of 1.0-1.7) or that were categorized within the upper half of the acceptable findings range (QF score of 1.8-2.1) were examined in greater detail and incorporated into the literature review for this study.

Table 4

Article ranking

<table>
<thead>
<tr>
<th>Quality Factor (QF) Score</th>
<th>Number of Articles (n = 51)</th>
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<tbody>
<tr>
<td>Strong (1.0–1.7)</td>
<td>n = 15</td>
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<tr>
<td>Acceptable (1.8–2.5)</td>
<td>n = 33</td>
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<tr>
<td>Weak (2.6–3.3)</td>
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<tr>
<td>Unreliable (3.4–4.0)</td>
<td>n = 1</td>
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Origins of Resilience Theory & Research

Despite the prevalence of trauma or adversity and the association with unfavourable mental health outcomes, resilience is by far the most common trajectory according to the most recent research on resilience (Bonanno, Brewin, Kaniasty, & La Greca, 2010; Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Bonnano, Romero, & Klein, 2015; Goodman, 2015; Miron, Orcutt, & Kumpula, 2014; Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017). The interest in resilience among researchers and within various helping professions has only intensified since this concepts’ first appearance in psychological research with young children and clinical psychiatry literature in the 1970s and 1980s (Bonnano, Romero, & Klein, 2015; Goodman, 2015; Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016; Ungar, Ghazinour, & Richter,
Resilience is generally defined as a psychological construct reflective of empirical findings that a large proportion of children exposed to trauma or adversity maintain healthy developmental trajectories and display positive long-term adjustment, adaptation, and functioning (Banyard & Williams, 2007; Bonnano, Romero, & Klein, 2015; Goodman, 2015). The emergence of these initial findings paralleled both: i) the increased attention to traumatic experiences across the life course and post-traumatic stress disorder (PTSD); and, ii) the evolution of Urie Bronfenbrenner’s social-ecological model of human development (Goodman, 2015; Ungar, Ghazinour, & Richter, 2013). Thus, the initial conceptualization of resilience offered a response to both the new-found interest in trauma within psychology and the implications of a social-ecological model of human development.

The inclusion of PTSD within the Diagnostic and Statistical Manual of Mental Disorders (DSM; APA, 1980, as cited in Goodman, 2015) served as a starting point in the conceptualization of trauma and its effects, with subsequent implications for research, clinical practice, diagnosis, and treatment (Bonnano, Romero, & Klein, 2015; Goodman, 2015). However, the diagnostic markers for post-traumatic stress (PTS) and PTSD are conceptual constructs influenced by both social and cultural factors, sparking controversy surrounding the cross-cultural validity of PTSD as a diagnostic construct (Horowitz & Wakefield, 2007, and McNally, 2003, as cited in Bonanno, Brewin, Kaniasty, & La Greca, 2010; Lykes & Mersky, 2006, and Summerfield, 1999, as cited in Lykes, 2013; Somasundaram & Sivayokan, 2013). Historically, this conceptualization of trauma promoted a focus on negative outcomes or deficits among survivors of trauma or adversity, with limited attention to the healing, growth, resilience,
and strengths of survivors (Dass-Brailsford, 2007, Harvey, 2007, Herman, 1997, Hyatt-Burkhard & Levers, 2012, and White, 2002, as cited in Goodman, 2015; Lykes, 2013; Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016; Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017; Ungar, Ghazinour, & Richter, 2013). The emphasis on PTSD has led to an empirical and clinical focus on the binary presence or absence of psychopathology, largely overlooking subclinical mental health symptomology, normative reactions to trauma or adversity, and capacities for resilience (Bonanno, 2004 as cited in Bonanno, Brewin, Kaniasty, & La Greca, 2010; Bonnano, Romero, & Klein, 2015). In turn, a focus on resilience both balances the overly negative binary conceptualization of trauma and psychopathology, and provides a more nuanced, contextualized conceptualization of individually- and contextual-variable reactions to trauma or adversity (Bonanno, Brewin, Kaniasty, & La Greca, 2010; Goodman, 2015).

Paralleling Bronfenbrenner’s social-ecological model of human development, the increased attention to resilience coincides with a multidimensional perspective of the impact of interactions between individuals, their experiences, and the social environment (Bonanno, Romero, & Klein, 2015; de Terte, Stephens, & Huddleston, 2014; Goodman, 2015; Miller-Graff, Howell, Martinez-Toreya, & Grein, 2016; Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016; Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017; Ungar, Ghazinour, & Richter, 2013). Within a social-ecological framework, development and wellbeing are theorized to be influenced by a model of person-environment (PxE) interactions, whereby well-resourced functional environments enhance the likelihood that positive individual characteristics will
contribute to favourable outcomes (Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017; Ungar, Ghazinour, & Richter, 2013). In light of recurrent findings illustrating a strong relationship between various sources of community and social support and resilience across the life course (Banyard & Williams, 2007; Bonanno, Brewin, Kaniasty, & La Greca, 2010; Bonnano, Romero, & Klein, 2015; de Terte, Stephens, & Huddleston, 2014; Feldman & Vengrober, 2011; MacMillan & Violato, 2008; Miller-Graff, Howell, Martinez-Toreya, & Grein, 2016; Miron, Orcutt, & Kumpula, 2014; Phillips, Auais, Belanger, Alvarado, & Zunzunegui, 2016; Ungar, Ghazinour, & Richter, 2013), the remainder of this literature review situates the current study within contemporary knowledge on resilience by drawing from recent empirical findings to articulate a social-ecological conceptualization of trauma, adversity, resilience, and community and social support.

**Trauma & Adversity**

Prior to exploring conceptualizations of resilience in more detail, it is necessary to explore the conceptualization of trauma and adversity as related constructs. Traditional conceptualizations of trauma, adversity, and PTS are grounded by the limits of social, cultural, and historical contexts, often defined by objective concepts removed from the subjectivity of lived experience, and largely overlook forms of trauma or adversity beyond finite or singular exposures to actual or threatened death, injury, or violence defined within the DSM-V (Bonanno, Brewin, Kaniasty, & La Greca, 2010; Goodman, 2015; Lykes & Mersky, 2006, and Summerfield, 1999, as cited in Lykes, 2013). For instance, within a longitudinal study of PTS and pre- and post-trauma risk and resilience factors among 573 university students exposed to a
2008 on-campus mass shooting, low-impact limited exposure was associated with clinically-significant levels of PTS, despite falling below the direct exposure diagnostic criterion for PTSD (Miron, Orcutt, & Kumpula, 2014). Put more simply, trauma-related mental health distress was not universally congruent to the level of exposure, and even limited exposure to trauma or adversity may negatively impact normative development, functioning, mental health, and psychosocial wellbeing. Thus, narrow conceptualizations of trauma or adversity may fail to encompass events or circumstances that fall below clinical thresholds, but that may be equally-distressing or impactful for survivors or individuals at-risk in conjunction with personal histories, subjective perceptions, and/or contextual variables. Failing to encompass personal histories, subjective perceptions, contextual variables, and subclinical exposure that results in significant mental health distress inadvertently excludes survivors and individuals at-risk who may benefit from trauma-informed resilience-building strategies based on arbitrary and rigid definitions of trauma or adversity.

A large proportion of the recent literature reviewed was focused on trauma and adversity in childhood, reflecting the well-documented negative impact of abuse, neglect, and family violence in early childhood (Greenfield & Marks, 2010; Kagan, Henry, Richardson, Trinkle, & LaFrenier, 2014; Kagan & Spinazzola, 2013; Overstreet & Mathews, 2011; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). Exposure to trauma, all forms of abuse, and various other ACEs have all been associated with disordered attachment and symptoms of complex PTSD (C-PTSD), including: impaired affect and impulse regulation, impaired cognitive functioning and sense of self, dissociation and somatization, difficulty in relationships,
depression, anxiety, substance use or chemical dependency, and psychosocial difficulties (Cloitre et al., 2005, Courtois, 2004, Herman, 1997, and van der Kolk & Courtois, 2005, as cited in Goodman, 2015; Cook, Blaustein, Spinazzola, & van der Kolk, 2003, as cited in Kagan, Henry, Richardson, Trinkle, & LaFrenier, 2014; Kagan & Spinazzola, 2013; Miller-Graff, Howell, Martinez-Toreya, & Grein, 2016; Overstreet & Mathews, 2011; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). Numerous findings from recent research highlight the association between parental adversity, family violence, and/or poor parental competence with: i) more immediate adjustment, emotional, and behavioural difficulties in young children; ii) reduced long-term social competence among children and adolescents; and, iii) higher levels of adult psychological distress, all resultant of the implications across relational, cognitive, institutional, and neurophysiological pathways (Cicchetti & Rogosch, 2001, Finkelhor, 1995, and Kendall-Tackett, 2002, as cited in Greenfield & Marks, 2010; MacMillan & Violato, 2008; Miller-Graff, Howell, Martinez-Toreya, & Grein, 2016; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). Notably, caregiver-related trauma or adversity during childhood and adolescence is considered especially influential to individual outcomes (Gest, Neeman, Hubbard, Masten, & Tellegen, 1993, as cited in MacMillan & Violato, 2008). The impact of childhood exposure to trauma or adversity is especially salient to conceptualizing resilience across the life course given the pervasive impact of childhood development as a result of the developmental stage-related impacts of such exposures (Kagan, Henry, Richardson, Trinkle, & LaFrenier, 2014; Kagan & Spinazzola, 2013).
Distinct from literature on ACEs and complex trauma in childhood, research and literature also indicate ethnic minorities in impoverished urban areas—especially ethnic minority youth—face disproportionate risk for violent trauma and co-occurring adversity (Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Overstreet & Mathews, 2011; Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016). However, much of the literature that initially identified this trend misattributed risk and negative outcomes to individual characteristics indirectly associated with ethnicity, while more recent research acknowledges this trend is likely an artifact of the sociocultural context of ethnic minorities living in urban areas coupled with systemic barriers and social and/or institutional oppression (Kwon, 2013, and Meyer, 2015, as cited in Alessi, 2016; Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Goel, Amatya, Jones, & Ollendick, 2014; Goodman, 2015; Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016). The attribution of this trend to sociocultural context, systemic barriers, and social or institutional oppression not only demonstrates the broader impact of the social-ecological environment on resilience, psychosocial wellbeing, and the realm of trauma or adversity—it also discredits racial, ethnic, and cultural myths and stereotypes related to the origins of risk and vulnerability.

Despite increased attention to cultural competency within the field of psychology, the diagnostic concept of PTSD has faced repeated criticism as an ahistorical and culturally-disembodied construct that often reduces complex collective phenomena and ongoing trauma to individual psychopathology and past or singular dimensions, respectively (Goodman, 2015; Lykes & Mersky, 2006, Summerfield, 1999, and Wessells, 2009, as cited in Lykes, 2013). Likewise, critical and cultural psychologists, anthropologists, and social constructivists have
argued that PTS symptom labels inadequately capture subjective experiences and reactions to trauma or adversity, or the process of meaning-making relative to sociohistorical context, culture, and place (Gergen, 1994, and Marecek & Hare-Mustic, 2009, as cited in Lykes, 2013). Alternatively, multiple authors have referred to a much broader range of traumatic experiences and adversities among ethnic minorities and other marginalized groups, underscoring how experiences of, understandings of, and reactions to trauma or adversity are influenced by sociocultural contexts (Alessi, 2016; Goodman, 2015; Lykes, 2013; Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016). For instance, American Indian Elders involved in community-based participatory research did not initially recognize historical trauma as a form of traumatic exposure or attribute it to their histories, yet readily used indigenous concepts to describe how generations of individuals, families, and communities have been traumatized by residential schools, assimilation policies, and systemic racism (Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016). Consequently, historical trauma, trans- or intergenerational trauma, race-based traumatic stress, and institutional betrayal trauma have been conceptualized as subtypes of trauma or adversity to account for the wide-ranging negative impact of colonization, government assimilation practices, and institutionalized power imbalances or injustices (Bryant-Davis & Ocampo, 2005, Carter, 2007, Fryd, 1997, Goodman, Vesely, Letiecq, & Cleaveland, in press, Harrell, Hall, & Taliaferro, 2003, Levers, 2012, Paradies, 2006, and Smith & Fryd, 2013, as cited in Goodman, 2015; Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016).
In light of the sheer breadth of potentially traumatic or adverse experiences, subjectivity, and individual and contextual variability, trauma and adversity are more accurately conceived as a spectrum of experiences where the subjective interpretation and impact of such experiences is immensely personal, individual, dramatically shaped by extraneous variables, and not able to be fully predicted or conceptualized based on objective dimensions alone (Bonnano, Romero, & Klein, 2015; Goodman, 2015; Miron, Orcutt, & Kumpula, 2014). Based on their own research and/or their review of past findings, multiple authors reiterated that severity, proximity, and/or frequency of exposure; dissociative symptomology; avoidant, inflexible, suppressive, and/or emotion-focused coping; both male and female gender; minority ethnic status; lower educational attainment; younger age; interpersonal trauma; cumulative life stress prior to and/or following exposure; pre-existing physical or mental health challenges; and resource change or loss have all been associated with higher risk for PTSD (Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Goel, Amatya, Jones, & Ollendick, 2014; Kagan, Henry, Richardson, Trinkle, & LaFrenier, 2014; Kagan & Spinazzola, 2013; Miron, Orcutt, & Kumpula, 2014). However, risk factors for PTSD have not gone unchallenged by research seeking to confirm them, given the emergence of findings that only partially support some risk factors and completely contradict others (e.g., see Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Goel, Amatya, Jones, & Ollendick, 2014).

The variability in predictive factors and individual outcomes observed within the literature review coincides with Bonanno and colleagues (2010; 2015) conclusion that individual outcomes are generally influenced by the context in which the trauma or adversity occurred and exposure to proximal (short-term) or distal (long-term) impacts, with numerous multivariate
Front-line perspectives

studies indicating there is no single, primary predictor of individual outcomes. Instead, most singular predictive variables exert small to moderate independent effects, while the cumulative interaction of risk and resilience factors is more predictive of individual outcomes (Bonanno, Brewin, Kaniasty, & La Greca, 2010; Bonnano, Romero, & Klein, 2015). Together, findings regarding: i) trauma and adversity in childhood; ii) individual and collective trauma or adversity among marginalized and/or minority groups; and, iii) the pervasive yet highly variable impact of trauma or adversity across the life course imply that the subjective experience and impact of trauma or adversity is not shaped so much by individual characteristics independent of context, but by the more nuanced interactions between individual and contextual variability, with the social-ecological environment exerting a multiplicity of effects across various domains of functioning that are often beyond individual control. Moreover, findings regarding the prevalence of ACEs and diverse forms of trauma or adversity suggest that narrow diagnostic considerations of singular finite events limited to threatened or actual injury, death, or violence profoundly underestimate the broader spectrum of subjective experiences, and thus may overlook the full scope of their impact on mental health and psychosocial wellbeing (Goodman, 2015; MacMillan & Violato, 2008; Miron, Orcutt, & Kumpula, 2014; Overstreet & Mathews, 2011; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). Consequently, a social-ecological perspective becomes especially salient to considerations of what defines trauma or adversity, how and why such experiences affect different people differently, and efforts to devise effective, targeted, evidence-based, trauma-informed resilience-building approaches for survivors of trauma or adversity and individuals at-risk.
Resilience

Resilience is commonly defined as positive coping, adjustment, and wellbeing despite significant threats to adaptation or development, with initial interest in this area dating back to developmental psychology research during the 1970s (Luthar, Cicchetti, & Becker, 2000, as cited in Alessi, 2016; Goodman, 2015; Garmezy, 1993, Masten, 2001, and Rutter, 1990, as cited in Greenfield & Marks, 2010; Phillips, Auais, Belanger, Alvarado, & Zunzunegui, 2016; Ungar, Ghazinor, & Richter, 2013). The focus on resilience, interchangeably referred to as a strengths-based perspective, emphasizes positive adaptation, strengths, assets, resources, and wellbeing as opposed to deficits, and is grounded in findings that although exposure to trauma or adversity often results in transient psychological distress, most individuals recover relatively quickly without lasting consequences (Bonnano, Romero, & Klein, 2015; Betancourt & Kahn, 2008, and Harvey, 2007, as cited in Goodman, 2015; Miller-Graff, Howell, Martinez-Toreya, & Grein, 2016; Shalev, 2002, as cited in Miron, Orcutt, & Kumpula, 2014; Phillips, Auais, Belanger, Alvarado, & Zunzunegui, 2016; Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017). However, more recent research on resilience has shifted from a focus on individual characteristics to a more inclusive account of social-ecological conditions and the ongoing interactions between dynamic individual and contextual factors, wherein these cumulative interactions are believed to exert much greater influence on resilience than singular factors (Bonnano, Romero, & Klein, 2015; Goodman, 2015; Hobfoll, Stevens, & Zalta, 2015; Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017; Ungar, Ghazinour, & Richter, 2013).
Within more recent research, social competence has received significant attention as a developmental component of resilience (Hines, 2015; MacMillan & Violato, 2008; Miller-Graff, Howell, Martinez-Toreya, & Grein, 2016). Miller-Graff and colleagues (2016) argued that conceptualizing social competence as being central to resilience directly aligns with a social-ecological perspective, whereby relational variables such as social support or child maltreatment directly and indirectly impact individual wellbeing through the promotion of social competence (Ungar, Ghazinour, & Richter, 2013). Although MacMillan and Violato (2008) identified parental competence and external social support as resource factors valuable to all children and adolescents, not just protective factors for those exposed to parental adversity (Luthar, Cicchetti, & Becker, 2000, Masten & Reed, 2002, and Werner & Smith, 1992, as cited in MacMillan & Violato, 2008), Miller-Graff and colleagues’ (2016) longitudinal study demonstrated that adversity indirectly influenced social competence via the development of adjustment problems, where appraisals of children’s social competence were dependent on reporter-specific social supports. Similarly, Hines’ (2015) qualitative meta-synthesis of studies on children’s coping and resilience to family violence also highlighted how supportive relationships within or outside of the family provide role models, encouragement, reassurance, and support that bolsters resilience, social competence, and psychosocial wellbeing.

However, Hines (2015) raised a salient point of debate within the field of resilience research–namely, whether resilience is an outcome or consequence of trauma, or a relatively stable trait (ego-resiliency)–while many other authors referred to resilience as a process (Banyard & Williams, 2007; Bonanno, Brewin, Kaniasty, & La Greca, 2010; Bonanno, Galea, Bucciarelli,
& Vlahov, 2007; Bonnano, Romero, & Klein, 2015; Hines, 2015; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). Although some research has indicated ego-, or trait-resilience is a significant mediator of anxiety, depression, and self-harm associated with childhood exposure to trauma or adversity (Philippe et al., 2011, as cited in Hines, 2015), most research has conceptualized resilience as a nonlinear process overlapping with recovery and often co-occurring with psychopathology (Alessi, 2016; Banyard & Williams, 2007; Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Hobfoll, et al., 2009; Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). In turn, resilience exists as a spectrum involving the coexistence of psychopathology, distress, and PTS alongside normative functioning, and is not synonymous with recovery (Alessi, 2016; Banyard & Williams, 2007; Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Leipold & Greve, 2009, as cited in de Terte, Stephens, & Huddleston, 2014; Goodman, 2015; Hobfoll, et al., 2009; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012; Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017).

Research with Indigenous populations, diverse cultural, religious, racial, and ethnic groups, and LGBTQ+ individuals has also brought greater attention to how dimensions of diversity and sociopolitical, socioeconomic, and sociocultural conditions shape resilience (Alessi, 2016; Hobfoll, et al., 2009; Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016; Somasundaram & Sivayokan, 2013). For instance, in Reinschmidt and colleagues’ (2016) community-based participatory research with American Indian Elders, Elders did not initially attribute resilience to their histories, yet used indigenous concepts and culturally-specific
descriptions to define resilience. Separately, Alessi (2016) documented the coexistence of severe trauma and hardship alongside resilience related to use of community and legal services, spiritual or religious support, and support from the LGBTQ+ community among a purposive sample of LGBTQ+ forced migrants in Toronto and New York, underscoring the need for broader clinical focus on practical support related to connecting individuals with community organizations to meet basic needs, providing social support, and assisting with legal processes beyond a sole focus on the psychological implications of trauma, adversity, discrimination, and oppression (Burnett & Peel, 2001, Epstein & Carrillo, 2014, and Shuman & Bohmer, 2014, as cited in Alessi, 2016).

Despite the need to account for intersecting identities and risk and protective factors within conceptualizations of resilience among diverse populations (Bowleg, 2013, Guruge & Khanlou, 2004, Meyer, 2015, Porter & Haslam, 2005, and Pumariega, Rothe, & Pumariega, 2005, as cited in Alessi, 2016), research on trauma, adversity, and resilience has faced criticism for omitting the disproportionate influence of social-ecological conditions and thereby largely neglecting the impact of historical trauma, oppression, intersectionality, and cultural variability, where ethnocentrism and homogeneous sampling may predispose blindness to culturally- and contextually-embedded risk and protective factors (Alessi, 2016; Goodman, 2015; Lykes, 2013; Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016; Somasundaram & Sivayokan, 2013; Rogoff, 2003, as cited in Ungar, Ghazinour, & Richter, 2013). Likewise, despite the prevalence of trauma or adversity across the life course and its potential short- and long-term impacts on development and adaptation, resilience is a relatively common trajectory among both
children and adults (Bonanno, Brewin, Kaniasty, & La Greca, 2010; Bonanno, 2005, Bonanno, Moskowitz, Papa, & Folkman, 2005, Bonanno, Rennicke, & Dekel, 2005, and Bonanno, Wortman, et al., 2002, as cited in Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Bonnano, Romero, & Klein, 2015; Goodman, 2015; Miron, Orcutt, & Kumpula, 2014; Overstreet & Mathews, 2011). Elevated PTS symptoms are frequently documented among both children and adults immediately following exposure to trauma or adversity, but rates of chronic symptomology rarely exceed thirty percent, with methodologically-sound studies reporting considerably lower prevalence rates. (Bonanno, Brewin, Kaniasty, & La Greca, 2010; Fletcher, 1996, as cited in Overstreet & Mathews, 2011).

**Social-ecological perspectives of resilience.** Although much of the research on resilience has been limited to person-centred risk and protective factors (Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Smith, Donlon, Anderson, Hughes, & Jones, 2015), Hobfoll, Stevens, and Zalta’s (2015) conservation of resources (COR) theory of resilience exemplified the disproportionate influence of the social-ecological environment on psychosocial wellbeing, mental health, and resilience following exposure to trauma or adversity. Drawing from extensive research on resilience across diverse populations and various forms of trauma or adversity, they proposed three resilience principles asserting that: i) resilience is associated with environments rich in accessible personal, social, material, and energy resources, and that provide safety and protection from resource loss while promoting resource gain; ii) the resources required for resilience are acquired across the life course, where individuals in resource-rich environments accumulate resource gains, while individuals in environments with fewer, unstable, or
inaccessible resources accumulate resource losses; and, iii) resource loss accumulation is both more rapid and powerful than equivalent resource gain accumulation because: a) it undermines resilience-building and compounds the negative impact on resilience by increasing the likelihood of further resource loss; and, b) resource gain accumulation is comparatively slow-moving and resource-dependent (Hobfoll, Stevens, & Zalta, 2015).

From a social-ecological perspective, resilience is frequently conceptualized as an ongoing process operating across multiple levels of the social-ecological environment despite difficulties operationalizing this conceptualization (Bonnano, Romero, & Klein, 2015; Ungar, Ghazinour, & Richter, 2013). Ungar, Ghazinour, and Richter’s (2013) social-ecological model of resilience provided a complex systems framework to illustrate how emergent systemic processes of person-environment (PxE) interactions across bio-, micro-, meso-, exo-, macro-, and chrono-systems shape resilience via complex interactions over the life course, in keeping with a social-ecological perspective of human development. Multiple theories and findings within their model correspond to findings within the literature review, including: i) the bio-systemic, developmental stage-related impact of childhood exposure to trauma or adversity (Bonnano, Romero, & Klein, 2015; Feldman & Vengrober, 2011; Kagan, Henry, Richardson, Trinkle, & LaFrenier, 2014; Kagan & Spinazzola, 2013; Overstreet & Mathews, 2011); ii) the positive impact of supportive micro-systemic interactions and meso-systemic processes of resource-exchange on resource stability, availability, and accessibility, and thus resilience (Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Bonnano, Romero, & Klein, 2015; Goel, Amatya, Jones, & Ollendick, 2014; Hobfoll, Stevens, & Zalta, 2015; Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017);

However, Ungar and colleagues (2013) also proposed the principles of differential impact and equifinality within their social-ecological model of resilience. According to these authors, the principle of differential impact accounts for why certain factors exert relatively small positive effects across the general population, yet have no effect or a larger than expected effect among those exposed to trauma or adversity, based on temporally- and/or contextually-variable impacts resulting from differential susceptibility to genetic risk factors and actual or perceived resource accessibility or availability (Ungar, Ghazinour, & Richter, 2013). The explicit focus on resource availability, accessibility, and barriers within this principle resembles findings from research on the impact of resource change or loss on resilience (Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Goel, Amatya, Jones, & Ollendick, 2014; Hobfoll, Stevens, & Zalta, 2015), and compliments the conceptual distinction between resource factors that exert positive effects for all individuals, and protective factors that buffer against the negative impacts of trauma or adversity (Luthar, Cicchetti, & Becker, 2000, Masten & Reed, 2002, and Werner & Smith, 1992, as cited in MacMillan & Violato, 2008).

Likewise, the principle of equifinality asserts that the social-ecological environment is just as influential as biology or genetics to resilience, if not more so, since PxE interactions and
manifest heritability are complicated by environmentally-mediated gene expression (Bronfenbrenner & Ceci, 1994, as cited in Ungar, Ghazinour, & Richter, 2013). Based on findings suggesting micro-systemic processes are less predictive of individual outcomes than meso- and macro-systemic processes that shape responses to stress (Ungar, 2011b, and Weine, Levin, Hakizimana, & Kahnweih, 2012, as cited in Ungar, Ghazinour, & Richter, 2013), these authors proposed a decentred, non-hierarchical understanding of resilience that acknowledges how changes in the odds stacked against individuals exert greater influence on outcomes than individual capacities for change. This principle compliments Bonanno and colleagues’ (2010; 2015) conclusion that risk and resilience trajectories are predicted by multiple dynamic individual and social-ecological variables, with singular variables exerting only small independent effects and the cumulative impact of these variables consistently emerging as the most significant predictor of resilience.

**Summary.** Together, the most recent research on resilience has demonstrated that: i) protective and risk factors vary across contexts and the life course, but show some consistency across childhood, adulthood, diverse populations, and various forms of trauma or adversity; and, ii) individuals may not be the most important locus for change given the independent effects of singular characteristics on resilience are much smaller than the disproportionate impact of the broader social-ecological environment and the interactions between characteristics (Banyard & Williams, 2007; Bonanno, Brewin, Kaniasty, & La Greca, 2010; Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Bonnano, Romero, & Klein, 2015; Goel, Amatya, Jones, & Ollendick, 2014; Hobfoll, et al., 2009; MacMillan & Violato, 2008; Miller-Graff, Howell, Martinez-Toreya, &
Grein, 2016; Phillips, Auais, Belanger, Alvarado, & Zunzunegui, 2016; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). Moreover, recent research on resilience has emphasized that resilience is a dynamic and multidimensional construct often clinically defined and empirically operationalized as positive developmental trajectories or adaptation following trauma or adversity, but is likely best conceptualized as an interactive process that exists on a continuum of adaptive and maladaptive functioning, and is dependent on the cumulative impact of highly variable individual- and context-specific risk and protective factors (Banyard & Williams, 2007; Bonanno, Brewin, Kaniasty, & La Greca, 2010; Bonanno, Galea, Buccionelli, & Vlahov, 2007; Bonnano, Romero, & Klein, 2015; Goodman, 2015; Hines, 2015; Hobfoll, et al., 2009; Miron, Orcutt, & Kumpula, 2014; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). Based on this conceptualization of resilience, the remainder of this literature review is focused on the role of community and social support in fostering resilience among survivors of trauma or adversity and individuals at-risk.

**Community & Social Support**

Recent research has indicated that social support from family and friends–and to a lesser extent, community support, sense of community, and communal mastery–are frequently associated with resilience (Alessi, 2016; Banyard & Williams, 2007; Bonanno, Brewin, Kaniasty, & La Greca, 2010; Bonnano, Romero, & Klein, 2015; Greenfield & Marks, 2010; Hines, 2015; Landau, 2010; Landau, Mittal, & Wieling, 2008; Overstreet and Mathews, 2011; Reinschmidt, Attakai, Kahn, Whitewater, and Teufel-Shone, 2016; Somasundaram and Sivayokan, 2016). Moreover, given greater capacity for change among relational characteristics
compared to more stable individual or contextual characteristics, findings regarding the protective effects of psychosocial resources imply that enhancing the availability, accessibility, and quality of community and social support may be one of the most viable approaches to fostering resilience (Bonnano, Romero, & Klein, 2015; Goodman, 2015; Greenfield & Marks, 2010; Hobfoll, et al., 2009; Hobfoll, Stevens, & Zalta, 2015; Miller-Graff, Howell, Martinez-Toreya, & Grein, 2016; Miron, Orcutt, & Kumpula, 2014; Overstreet & Mathews, 2011; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012; Ungar, Ghazinour, & Richter, 2013). Thus, the remainder of this chapter further describes the relationship between resilience and community and social support as presented in research in this area, with a focus on the potential to foster resilience through community and social support among survivors of trauma or adversity and individuals at-risk.

In keeping with the distinction between resource factors beneficial for all individuals and protective factors specifically beneficial in the face of trauma or adversity (Luthar, Cicchetti, & Becker, 2000, Masten & Reed, 2002, and Werner & Smith, 1992, as cited in MacMillan & Violato, 2008), social support is theorized to exert both main and buffering effects, with main effects corresponding to the resource value of social support for all individuals, and buffering effects reflecting its protective value in the presence of exposure to trauma or adversity (Armstrong, Birnie-Lefcovitch, & Ungar, 2005, as cited in MacMillan & Violato, 2008). Thus, multiple studies have documented the absence of statistically significant effects of social support in the presence of exposure to trauma or adversity, given social support exerted a positive influence on competence, resilience, and wellbeing regardless of exposure (Bachman DeSilva, et
al., 2012; Goel, Amatya, Jones, & Ollendick, 2014; MacMillan & Violato, 2008). Similarly, Greenfield and Marks (2010) initially found sense of community was associated with positive adult mental health outcomes regardless of childhood exposure to family violence in their large-scale analysis, also in keeping with the conceptual distinction between resource factors that exert main effects and protective factors that exert buffering effects in the presence of exposure to trauma or adversity (Armstrong, Birnie-Lefcovitch, & Ungar, 2005, Luthar, Cicchetti, & Becker, 2000, Masten & Reed, 2002, and Werner & Smith, 1992, as cited by MacMillan & Violato, 2008).

However, once Greenfield and Marks (2010) identified three profiles of childhood exposure to family violence as risk categories for adult psychological distress, sense of community emerged as a significant protective factor within the most severe profile, suggesting that sense of community is more accurately conceptualized as a protective factor that exerts buffering effects in the face of more severe trauma or adversity, despite its generalized main effects as a resource factor. Likewise, Goel and colleagues (2014) also offered two potential explanations for why their findings contradict the buffering protective effects of social support, noting: i) the impact of residential fires may have been too distressing to be mitigated by social support; and, ii) residential fires likely resulted in a family-wide inability to provide adequate support to children, in keeping with research demonstrating caregivers may be unable to address children’s needs depending on their own psychological wellbeing (Laor et al., 2001, Spell et al., 2008, and White & Renk, 2012, as cited in Goel, Amatya, Jones, & Ollendick, 2014). Although community and social support likely function as resource factors for all individuals, the
incidental absence of associations with resilience may be an artifact of narrow operational definitions of resilience, the specific trauma or adversity studied, or limited attention to other moderating variables (Bachman DeSilva, et al., 2012; Goel, Amatya, Jones, & Ollendick, 2014; MacMillan & Violato, 2008), where community and social support appear to be especially protective in the presence of more exposure to more severe trauma or adversity so long as such support has not been compromised.

Findings from the literature review also indicated that social support exerts indirect protective effects via multiple pathways. Within Miller-Graff and colleagues’ (2016) analysis of child protective services (CPS) reports and nation-wide LONGSCAN data, they found that social support exerts direct and indirect effects on children’s social competence, whereby ratings of children’s social competence were dependent on reporter-specific social support, with greater social support among caregivers increasing caregiver-reports of children’s social competence, and greater social support among children increasing child-reports of their social competence. Similarly, Feldman and Vengrober’s (2011) analysis of Israeli families exposed to rocket fire highlighted how lack of maternal psychopathology and social support are social-ecological assets central to caregiver and child attachment and wellbeing, especially during exposure to trauma or adversity, given that maternal proximity to traumatic events was more predictive of childhood PTSD than children’s actual exposure. Notably, mothers of exposed children with PTSD reported higher rates of depression, anxiety, and PTSD compared to mothers of exposed children without PTSD, who also reported higher levels of social support. These findings are particularly
valuable to understanding the nexus between resilience, social competence, and the social-ecological environment, as well as the direct and indirect impacts of social support on resilience.

Although coping is regarded as a process distinct from resilience, Smith and colleagues’ (2015) proposed a variation of the enabling hypothesis of coping that holds significant explanatory power regarding the indirect effects of social support on resilience. Smith and colleagues (2015) hypothesized that in contexts of collective trauma characterized by shared experiences, the positive effects of support-seeking on perceptions of social support, self-efficacy, and negative affect may be enhanced over time via maximally applicable social support and social modeling. Using a rigorous analysis of longitudinal data from survivors of the 2007 Virginia Tech mass shooting, they found support for their hypothesis based on the direct effects of support-seeking and the indirect effects conditional on PTS severity. Support-seeking reduced distress by working through mediator variables in serial order, where support-seeking increased perceived social support, which increased self-efficacy, yet this effect was conditional on PTS severity where support-seeking did not have significant indirect effects in the presence of low-level PTS, but had increasingly significant positive indirect effects in the presence of higher levels of PTS (Smith, Donlon, Anderson, Hughes, & Jones, 2015). Again, these findings demonstrate the direct and indirect impacts of community and social support on resilience and psychosocial wellbeing, and suggest that community and social support are especially protective in the presence of more severe trauma-related mental health distress, although these protective effects are largely dependent on the context and quality of such support.
Overall, the expansive body of literature on childhood resilience has demonstrated the protective buffering and mediating effects of competent, nurturing parenting and perceived and actual social support against the negative effects of childhood exposure to trauma or adversity (Bachman DeSilva, et al., 2012; Bonnano, Romero, & Klein, 2015; Feldman & Vengrober, 2011; Goel, Amatya, Jones, & Ollendick, 2014; MacMillan & Violato, 2008; Miller-Graff, Howell, Martinez-Toreya, & Grein, 2016). Although the protective effects of community and social support appear more pronounced in developmental and child psychology literature, likely as a result of the disproportionate focus on resilience and ACEs in this same body of literature, a similar pattern of findings is evident in resilience research with adults. Among adult survivors of childhood trauma or adversity, social support and sense of community are key to establishing an effective recovery environment (Herman, 1992, as cited in Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012), and are correlated with recovery over time despite recurrent trauma beyond childhood exposure (Banyard & Williams, 2007; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012).

Furthermore, research on resilience and adult exposure to trauma or adversity has also indicated that positive adjustment and psychosocial wellbeing are associated with various forms of social support, perceived support, and support-seeking behaviour (Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Bonnano, Romero, & Klein, 2015; de Terte, Stephens, & Huddleston, 2014; Miron, Orcutt, & Kumpula, 2014; Phillips, Auais, Belanger, Alvarado, & Zunzunegui, 2016; Smith, Donlon, Anderson, Hughes, & Jones, 2015). Likewise, the absence of social support among adults exposed to trauma or adversity has repeatedly been associated with
PTSD and unfavourable mental health outcomes, while the presence of social support is consistently associated with resilience and recovery over time (Davidson et al., 1991, and Koenen et al., 2003, as cited in Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Bonnano, Romero, & Klein, 2015; DuMont et al., 2007, Jonzon & Lindblad, 2006, and Wright et al., 2005, as cited in Greenfield & Marks, 2010; Littleton et al., 2009, as cited in Miron, Orcutt, & Kumpula, 2014). Moreover, a large frequently-cited meta-analysis by Brewin, Andrews, and Valentine (2000, as cited in Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Landau, Mittal, & Wieling, 2008; and Miron, Orcutt, & Kumpula, 2014) also suggested that a lack of post-trauma support is the strongest predictor of PTSD beyond pre-trauma or event-level factors.

However, the relationship between community and social support and resilience is also subject to population- and context-specific nuances, with some studies having illustrated gender differences in the relationship between social support and resilience as a result of gendered social norms, suggesting that women are more likely to focus inward on support received from family while men may be more likely to turn outward to support from peers or professional colleagues (de Terte, Stephens, & Huddleston, 2014; Iyer, Sen, & Ostlin, 2008, and Wilson, 1992, as cited in Phillips, Auais, Belanger, Alvarado, & Zunzunegui, 2016). Separately, other studies have revealed place-based effects of community and social support via context-specific cultural norms (Phillips, Auais, Belanger, Alvarado, & Zunzunegui, 2016) and the psychology of place (Cox & Perry, 2011). Lastly, research on resilience with diverse populations illustrates both the protective effects of community and social support as well as how such support may be limited among marginalized or minority populations. For instance, Indigenous peoples living in urban
areas frequently experience the loss of community and social support gained from living on tribal lands or reserves, as well as gaps in culturally-relevant physical and mental healthcare, limited access to community resources, and continued racism and discrimination, yet derive substantial meaning from cultural influences on resilience related to individual, familial, and communal connections to Indigenous culture and heritage (Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016). Similarly, support from diversity- and identity-affirmative community groups and use of community and legal services have been found to contribute to resilience via identity-formation and the fulfillment of basic needs, yet individuals belonging to minorities or marginalized groups may be reluctant to engage community groups or supportive services due to concerns related to discrimination, stigma, and ethnocentricity (Alessi, 2016).

**Summary**

Overall, a large proportion of research on resilience has highlighted the direct and indirect protective effects of community and social support across the life course, the impact of community and social support as components of resource-rich social-ecological environments, and the importance of individual, social, contextual, and intersectional determinants of resilience independent of exposure to trauma or adversity. Despite the considerably nuanced relationship between community and social support and resilience related to its individually- and contextually-variable effects, not only are community and social support beneficial to psychosocial wellbeing among all individuals—they are also integral components of resilience, adaptive coping, and recovery (Banyard & Williams, 2007; Greenfield & Marks, 2010; Smith, Donlon, Anderson, Hughes, & Jones, 2015; Tummala-Narra, Kallivayalil, Singer, & Andreini,
Moreover, multiple authors have reiterated that the development of community-based interventions and outreach initiatives should continue to focus on trauma-informed systems-based interventions that enhance individuals’ existing community and social support networks as a means to foster resilience (Hines, 2015; Smith, Donlon, Anderson, Hughes, & Jones, 2015; Lykes, 2013; Overstreet & Mathews, 2011; Somasundaram & Sivayokan, 2013). Many of these same authors also discussed the need for both prevention and intervention initiatives, and cross-disciplinary collaboration involving individuals, families, schools, care providers, community and social services, justice and welfare institutions, and other stakeholders (Agani, Landau, & Agani, 2010; Hines, 2015; Landau, 2010; Landau, Mittal, & Wieling, 2008; Lykes, 2013; Overstreet & Mathews, 2011). Consequently, there is increased attention to trauma-informed psychosocial interventions adopting a social-ecological perspective to leverage existing individual- and context-specific resources to support the inherent resilience and connectedness of individuals, families, and communities (Agani, Landau, & Agani, 2010; Landau, 2010; Landau, Mittal, & Wieling, 2008; Overstreet & Mathews, 2011).
Chapter 3 – Research Methodology

Scope & Data Collection Procedure

Research Questions & Scope

This qualitative graduate-level study employed a hybridized thematic analysis of data generated through semi-structured in-depth interviews with a purposive snowball sample of ten community and social service professionals to answer the following questions:

1. How is resilience conceptualized among community and social service professionals?
2. What role do community and social support play in fostering resilience?
3. How can community and social services foster resilience among survivors of trauma or adversity and individuals at-risk?

Sampling & Participants

Recruitment consisted of a purposive snowball sample of the principal investigator’s professional contacts within Simcoe County, Ontario. Ten community and social service professionals were recruited to participate in in-depth interviews via an informational email flyer and participant referrals, beginning with the principal investigator’s primary contacts at a local non-profit organization serving individuals who are homeless, criminalized, or marginalized, and at a local women’s shelter for survivors of intimate partner violence and/or human-trafficking. The contact at the latter organization consented to participating in the research, and four additional professionals from the former organization were recruited through referrals from the primary contact, who also participated. These participants then referred one professional from a
regional in-patient mental health centre, and to a local branch of a nationally recognized mental health association where three additional professionals were recruited. Based on prior research demonstrating the feasibility of achieving data saturation via six to twelve in-depth interviews within purposive, relatively homogenous samples (Guest, Bunce, & Johnson, 2006), ten interviews with community and social service professionals were projected to achieve data-saturation within this study.

To be eligible for recruitment, participants had to possess professional experience related to the development, implementation, or provision of trauma-informed services for survivors of trauma or adversity and individuals at-risk, be over the age of eighteen years old, fluent in English, and able to personally give informed consent to participate in the study. Participation consisted of an in-depth interview no more than two hours in length with the option for participants to personally review and approve their interview transcripts. However, none of the participants requested to review and approve their transcripts. Although no formal inducements were offered to participants for their contributions, all participants were provided with a twenty-five dollar (CAD) gift card as a token of thanks at the conclusion of their interview.

**Ethical Considerations & Interview Procedures**

Informed consent was obtained prior to each in-depth interview (see Appendix A). Semi-structured in-depth interviews were conducted face-to-face, were audio-recorded using a handheld audio-recording device, and used non-invasive open-ended and follow-up questions in order to clarify responses, prompt elaboration, and initiate a dialogue on the research topic (see Appendix B). The interview procedure was designed to engage professionals as collaborators
(Kiefer, 2006) and field experts, and to generate experientially-credible and professionally-relevant data (Maxwell, 2009) regarding: i) community and social service professionals’ backgrounds; ii) professional experiences with survivors of trauma or adversity and individuals at-risk; iii) professional understandings of resilience; iv) professional understandings of the role of community and social support following trauma, adversity, and in fostering resilience; and, v) how community and social services can foster resilience among survivors of trauma or adversity and individuals at-risk.

Audio-recordings of interviews were manually transcribed and anonymized to produce interview transcripts for further analysis. All audio-recordings and original transcripts were permanently destroyed once anonymized transcripts were prepared. Within the informed consent form and prior to each interview, participants were offered opportunities to: i) be notified when the audio-recording of their interview had been permanently destroyed; ii) to review and approve their anonymized transcript; and, iii) to select pseudonyms for use within the final publication. Only one participant asked to be notified when the audio-recording of their interview was destroyed, and none of the participants requested to review and approve their anonymized interview transcripts. If participants declined to select a pseudonym, they were informed that the principal investigator would assign a pseudonym to their anonymized interview transcript with no record linking this pseudonym to their identity. Pseudonyms were chosen by participants or assigned by the principal investigator for the purpose of protecting participants’ anonymity, yet the option for participants to select their own pseudonym was provided to enable participants to personally re-identify their contributions to the study following publication. Within both the
informed consent form and prior to the interview procedure, all participants were informed that their selection of a pseudonym would enable the principal investigator to re-identify the participant within the analysis and research publication. However, participants were advised that the choice to disclose their involvement and/or the use of a pseudonym within this study is solely at their discretion, and that their involvement is entirely confidential and their identity will remain anonymous. All prospective participants were informed of their right to refuse to participate or withdraw from the study in the email recruitment flyer, informed consent form, prior to and following each interview, and again if they chose to be notified when their audio-recording had been destroyed and/or to review and approve their anonymized transcript. Likewise, all prospective participants were informed of the measures taken to protect privacy, confidentiality, and anonymity, the potential risks and benefits associated with participation, and the data storage procedures and record retention plan within the informed consent form.

The scope, data collection procedure, and analysis outlined for this study was approved by the Royal Roads University Research Ethics Board and conforms to the guidelines and minimal-risk standards within the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans. Given the purposive snowball sample was initiated using the principal investigator’s network of professional contacts, the potential for coercion or undue influence on prospective participants’ decisions to participate was addressed as a preeminent ethical concern within this study. Among the ten professionals recruited to participate, five belonged to the principal investigator’s network of professional contacts and subsequently referred other participants with an arms-length relationship to the principal investigator. However, participant
recruitment for this study was initiated through two professionals within the sample, only one of whom served as the primary contact within their respective workplace to disseminate the email recruitment flyer. Therefore, the principal investigator did not personally recruit or invite all but two prospective participants to participate in this study. To avoid implied and/or actual coercion or undue influence, the principal investigator disclosed the full purpose, scope, and parameters of this study as well as her affiliations with any academic and/or professional institutions, and requested that prospective participants disregard her professional affiliations and any prior existing relationship with her in making their fully voluntary decision to participate. All prospective participants were instructed within the informational email recruitment flyer, informed consent form (Appendix A), and immediately prior to their interview to make their own independent, voluntary decision to participate in this study regardless of their relationship to the principal investigator, although this instruction was especially emphasized for prospective participants within the principal investigator’s network of professional contacts.

**Analysis Framework & Procedure**

A hybridized thematic analysis (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006) was conducted following the manual transcription and anonymization of raw interview data. A contextualist methodological orientation was adopted within this analysis to integrate both essentialist and constructivist perspectives of lived experience and subjective meaning (Braun & Clarke, 2006). The hybridized thematic analysis involved both deductive and inductive coding to derive patterns and themes through the analysis of raw participant data in conjunction with
existing theories, concepts, and research findings (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006).

**Analysis Framework**

Thematic analysis lends itself to the current study given its flexibility, compatibility with qualitative research, utility in summarizing patterns and trends across data, opportunities for concurrent social constructivist and psychological essentialist interpretations, and ability to offer thick descriptions of data and concepts (Braun & Clarke, 2006). Moreover, hybridized coding within thematic analysis incorporates the benefits associated with inductive theorizing alongside the deductive integration of existing constructs as heuristic tools or ideal types (Braun & Clarke, 2006; Schutz, 1967, as cited by Fereday & Muir-Cochrane, 2006). By incorporating existing constructs via deductive, theory-driven coding for consistency with experiential participant data, alongside concurrent inductive, data-driven coding of organic trends and themes, this hybridized thematic analysis integrates existing constructs as tools for pattern recognition, yet is grounded in the subjective understanding, experiences, and professional knowledge of participants (Boyatzis, 1998, and Crabtree & Miller, 1999, as cited by Fereday & Muir-Cochrane, 2006). Within this analysis, relevant theories, concepts, and findings from the systematic review of literature have been utilized as “heuristic tools” (Coffey & Atkinson, 1996, p. 157, and Kelle, 1995, p. 41, as cited by Richardson & Kramer, 2006, pp. 500-501) to facilitate a theory-in-action approach to what is dually theoretically- and experientially-grounded theorizing. Drawing from the systematic review of recent literature on trauma, adversity, resilience, and community and social support, existing theories, concepts, and research findings have been used to develop a priori
codes for deductive coding (see Table 6, Appendix C) alongside concurrent inductive coding using data-driven in vivo codes (Elliot, 2018; Boyatzis, 1998, and Crabtree & Miller, 1999, as cited by Fereday & Muir-Cochrane, 2006; Ryan & Bernard, 2003; Saldana, 2008).

**Analysis Procedure**

The hybridized thematic analysis was conducted as per the six-phase model proposed by Braun and Clarke (2006), wherein data coding was filtered based on which data explicitly answer the research questions (Saldana, 2008). Data were coded using a comprehensive approach that employed three phases of coding using a manual cut-and-sort method and scrutiny techniques to identify repetitions, organic and theory-related typologies, and differences and similarities across the data set (Ryan & Bernard, 2003). The initial phase consisted of an open coding process using inductive in vivo codes as well as deductive a priori codes identified through the literature review (Table 6, Appendix C) to compile preliminary descriptive codes that were subsequently categorized as topics relevant to the research questions (Elliot, 2018; Ryan & Bernard, 2003; Saldana, 2008). The second phase of coding consisted of manually transferring preliminary codes to an electronic format and subsequently re-coding and re-categorizing preliminary codes and topic-based categories to develop tentative theme-based categories and codes based on likeness and conceptual linkages (Elliot, 2018; Ryan & Bernard, 2003). The third and final phase of coding consisted of merging, collapsing, and refining the theme-based categories and codes to develop conceptual themes relevant to each of the research questions (see Table 7, Appendix D).
Use of both deductive a priori codes and data-driven, inductive in vivo codes enabled examination of consistency between pre-existing constructs and participant data, and the development of themes based on organic similarities, differences, and patterns within the data set, respectively (Elliot, 2018; Boyatzis, 1998, and Crabtree & Miller, 1999, as cited by Fereday & Muir-Cochrane, 2006; Ryan & Bernard, 2003; Saldana, 2008). In doing so, this analysis incorporated existing theoretical and empirical knowledge related to trauma, adversity, resilience, and community and social support as tools for pattern recognition, yet is grounded in the lived practical and professional experience of front-line professionals. Thematically, the analysis was designed to: i) capture the unique perspectives, expertise, and experiences of community and social service professionals; ii) compare theoretical, clinical, and intuitive conceptualizations of resilience; iii) identify the utility and relevance of community and social support as psychosocial determinants of resilience; and iv) triangulate the relationship between trauma, adversity, resilience, and community and social support.
Chapter 4 - Results

Five key themes were identified through the hybridized thematic analysis of in-depth interview data with a purposive sample of ten community and social service professionals (see Table 5). The first two themes regarding resilience as a three-part construct and secondary conceptual considerations pertain to the research question of how professionals conceptualize resilience. The third and fourth themes regarding the continuum of risk and protection and community and social support address the research question of how professionals conceptualize the role of community and social support. Finally, the fifth theme encapsulates service and approach considerations related to service design and trauma-informed resilience-building strengths-based approaches in response to the research question of how can community and social services foster resilience among survivors and individuals at-risk. Although these themes

Table 5

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<th>No.</th>
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<td><em>How is resilience conceptualized among community and social service professionals?</em></td>
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<td>1</td>
<td>Resilience as a three-part construct</td>
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<td>2</td>
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<td><em>What role do community and social support play in fostering resilience?</em></td>
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<td>Continuum of risk and protection</td>
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<td>4</td>
<td>Community and social support</td>
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<td><em>How can community and social services foster resilience among survivors of trauma or adversity and individuals at-risk?</em></td>
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<td>Service and approach considerations</td>
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formed distinct topic-based categories within the data set, multiple characteristics and sub-themes are closely interconnected and cannot be fully disentangled.

**Participant Backgrounds**

The community and social service professionals who participated in this study possessed an average of ten years of experience providing trauma-informed services to survivors and individuals at-risk, ranging from two to over forty years of experience with varied educational and professional backgrounds (see Table 8, Appendix E). Five professionals worked within a local organization serving individuals who are homeless, criminalized, or marginalized; three professionals worked within a local branch of a nationally recognized mental health association; one professional worked within a local women’s shelter for survivors of intimate partner violence and/or human trafficking; and one professional worked at a regional in-patient mental health centre. All but the latter professional worked in the non-profit sector. All professionals recruited to participate in this study possessed undergraduate degrees or diplomas in related fields such as psychology, sociology, social work, nursing, addictions counselling, and mental health counselling, social service work, and child and youth social service work. However, one professional also possessed a graduate social work degree and another was in the process of completing a graduate degree in counselling psychology. All of these professionals possessed extensive experience working with survivors of trauma or adversity and individuals at-risk over the course of their careers, describing daily or almost daily interactions with such clients. All interview data and quotes or excerpts have been anonymized and all participant identities have been replaced with pseudonyms selected by participants or assigned by the principal investigator.
Theme 1: Resilience as a three-part construct.

The first theme pertains to participants’ conceptualizations of resilience as a three-part construct comprised of trait-, outcome-, and process-based components. Although these components were distinct across the data set, many participants inadvertently described resilience as a trait, outcome, and process within the same interview. Moreover, there was considerable overlap in their conceptualizations of trait-, outcome-, and process-based components of resilience, such as the inability to distinguish resilience as a trait activated by traumatic or adverse experiences; versus an outcome following trauma; versus a process involving the ongoing, nonlinear progression through phases or stages. In turn, participants’ conceptualization of resilience is best articulated as a complex construct encompassing interactive trait-, outcome-, and process-based components with special emphasis on resilience as a dynamic, ongoing, and nonlinear process.

Trait-based resilience. Participants consistently described trait-based resilience as being universal, related to various other traits, and as being both innate and able to develop over time. Nine of the ten participants described having observed resilience among a diverse range of clients despite the presence of recurrent trauma, adversity, or significant risk factors. Such observations led them to come to their own conclusions about the universal nature of resilience—namely, that: “everyone has some amount of resilience” (Sarah); “[resilience is] something that everyone has within themselves, at all different levels and different tools” (Caroline); and “we all have [resilience], it’s just whether or not – people just don’t always know the name of it” (Lori).
Likewise, participants described how trait-based resilience is influenced by the combined effects of other personality traits or characteristics, including hope and optimism, positive temperament, self-awareness, inner strength and motivation, sense of humour, sense of self or identity, self-esteem and self-worth, and openness and a willingness to ask for help, although resourcefulness was the most frequently cited trait or characteristic related to resilience. They also described the potential for trait-based resilience to be innate among some individuals, alongside the potential for resilience to evolve or develop over time. For instance, two participants explicitly described what they perceived as a biological predisposition and the potential for inherent resilience. One participant broadly explained how “there are exceptions or people who have nobody in their lives and have suffered severe trauma and still find a way to push through, and those people have inherently a massive amount of resilience […]” (Caroline), while the latter elaborated:

[...] I do think there is like a predisposition towards it, perhaps [...] I do think that nature versus nurture, that there is some biological benefits to, even babies, you know, studies on babies that some cry the whole time in the nursery and some are content, and just, I think there is a predisposition that people have [...] (Cheyenne)

Thus, all participants concluded it was difficult to identify whether trait-based resilience was truly innate, and surmised that it is more accurately understood as an interactive trait, regardless of its innateness:

I think [resilience] is, it is a bit of a trait in and of itself, but that’s dependent on all these other things… Like your history, your biology, your connections, your
supports, all of those things… It could be location, right? Like what country are you in? What’s the culture you’re in? Everything… (Cheyenne)

Another participant pondered similar questions about the origins of resilience among survivors and individuals at-risk:

[…] it’s hard to say whether there’s some sort of inherent resilience in certain people–you definitely meet certain people and you think, you know, how are they getting through? Like, how is this happening? And not only, like, how are they getting through? But how are they thriving? But it’s hard to define where that comes from for people. Is it upbringing? Is it just inherently the way they are? Is it the fact that they’re well supported? (Sarah)

Overall, participants struggled to identify the origins of resilience among survivors and individuals at-risk, yet recognized how resilience may be shaped by other personality traits, characteristics, or temperament, and readily identified trait-like characteristics of resilience.

**Outcome-based resilience.** When discussing resilience as an outcome, eight of the ten participants described resilience as a prevalent outcome following trauma or adversity, although a minority noted that resilience can be difficult to achieve or maintain within the immediate aftermath of trauma or adversity or among some individuals, such as those with comorbid developmental delays, physical or mental health problems, and/or substance use or chemical dependency. Participants also described outcome-based resilience as a “silver lining” (Sarah) to trauma or adversity, where these experiences can serve as a source of lessons learned and opportunities to build inner strength. The following quote eloquently illustrates this point:
[...] sometimes [trauma or adversity] can be strengthening in the end or in the long run, and you can learn things from that, and you having to be in a position where you have to cope, and you have to find a way forward, is a strength. Like, you are building strengths as you try to tackle all of these things, so you might… In some circumstances, in the long run and depending on how resilient you were and how you were able to move forward, you might end up better, just a more knowledgeable person, stronger than maybe you would have been had you not had anything to overcome. (Cheyenne)

In turn, participants recognized experiences of trauma or adversity as distressing and potentially harmful to psychosocial wellbeing, yet acknowledged the potential for such experiences to afford opportunities to learn from challenges and build strength and coping skills in a manner that contributes to resilience.

**Process-based resilience.** Participants also described resilience as an ongoing nonlinear process that evolves through phases and stages. For example, participants described how resilience is a continuous process that progresses at different rates for different individuals, where “there’s just no finish-line [for resilience]” (Marie). Although almost all participants explicitly referred to resilience as a trait during the course of their interviews, many of their descriptions of the development of this trait over the life course appear to reflect process-based components of the three-part construct of resilience. For instance, one participant explained how resilience “becomes a trait in day-to-day living even when [survivors] are removed from the trauma” (Terri), where although they referred to resilience as a trait, their articulation reflects
how the development and manifestation of this trait occurs through a process that unfolds through daily living across the life course. Additionally, participants explained how resilience typically evolves in phases or stages given the need for survivors and individuals at-risk to re-establish equilibrium and to digest, process, and understand their experiences in the immediate aftermath of trauma or adversity, followed by subsequent phases and stages that involve returning to routine and mundane activities of daily living, the readiness to seek support from others, and acceptance and forgiveness. However, participants also emphasized that survivors and individuals at-risk almost all universally progress through an acute survival stage characterized by a preeminent focus on responding to the crisis, its immediate aftermath, and addressing basic needs, where “survival becomes a matter of fighting against essentially all the odds” (Joanne). Yet beyond participants’ distinction between trait-, outcome-, and process-based components of resilience, they elaborated on this construct further by highlighting three additional domains of secondary conceptual considerations for resilience.

**Theme 2: Secondary conceptual considerations.**

The second theme expands on participants’ conceptualizations of resilience by highlighting definitions of trauma and adversity, dimensions of diversity, and the distinction between and coexistence of resilience with recovery and distress as three domains of secondary conceptual considerations relevant to resilience. Beyond their conceptualization of resilience as a three-part construct comprised of trait-, outcome-, and process-based components, participants also relied on definitions of trauma and adversity, an intersectional understanding of dimensions of diversity, the distinction between resilience and recovery, and the potential for resilience to
coexist with trauma-related mental health distress to inform their understanding of resilience. Overall, definitions of trauma and adversity, dimensions of diversity, and the coexistence with and distinction between recovery, resilience, and distress directly informed how participants understood the range of subjective human experiences as being traumatic or adverse and the variability in resilience trajectories and manifestations. Likewise, dimensions of diversity informed participants’ understandings of unique manifestations of resilience and the potential for individual-, gender-, racial-, ethnic-, and cultural-variability, wherein definitions of trauma and adversity that account for a diverse range of subjective experiences and reactions were tied to their understanding of how the development and manifestation of trait-, outcome-, and process-based components of resilience may vary across contexts and individuals. Lastly, the coexistence of resilience with distress and distinction between recovery and resilience informed participants’ conclusions that both resilience and recovery are ongoing processes, especially in light of definitions of trauma and adversity that recognize the under-reported prevalence of such experiences, accumulation across the life course, and the potential for chronic exposure and recurrent re-traumatization, wherein the trajectory and nature of trait-, outcome-, and process-based resilience are further shaped by dimensions of diversity.

**Definitions of trauma and adversity.** Participants relied on definitions of trauma and adversity grounded by their observations of a ‘snowball effect’ within the life course accumulation of traumatic or adverse experiences to inform their conceptualizations of resilience. Participants rejected the notion of trauma or adversity as a singular cataclysmic event or crisis, and instead referred to a snowball as a metaphor for how traumatic or adverse
experiences accumulate across the life course, and can initiate a cascade of subsequent events that compound the impact of the original trauma or adversity:

I think when a lot of the times when we define [trauma] with clients, we talk about that people have the perception that trauma is this one big bad event that’s happened, and it’s not always that… It could be almost more—I always describe it like a snowball—something can happen and then you don’t necessarily have the skills to cope with that and more things can pile on and on to that snowball and then sometimes it [gesticulating] pew! Explodes! (Sarah)

Participants’ understanding of the snowball effect of trauma or adversity accumulation across the life course seemed to shape their attention to complex trauma, childhood exposure to trauma and ACEs, and gender-specific trauma or adversity. They noted that for the majority of the individuals they work with, experiences of trauma or adversity began in early childhood, often involved family members or close interpersonal relationships, and eventually evolved into continued traumatization through interpersonal relationships, homelessness, marginalization or exploitation, and/or criminalization. Similarly, they described specific attention to the nuances of gender-specific trauma or adversity, including the gendered-impact of trauma on female survivors of sexual assault, and traumatic sports-related head injuries among young male athletes, with explicit consideration of gender norms and stereotypes related to trauma, mental health, and socially-acceptable trauma reactions and coping behaviours.

Participants’ articulation of the snowball effect of trauma or adversity accumulation across the life course led them to elaborate on the prevalence of triggers and re-traumatization related to
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day-to-day living, micro-aggressions and language, intimacy, interactions with law enforcement and the criminal justice system, familial and interpersonal relationships, and homelessness, safe housing, and domestic environments. Three participants described anecdotes to illustrate the triggering or re-traumatizing impact of seemingly mundane or normative aspects of daily life, with the first participant elaborating on the triggering nature of physical intimacy versus sex work:

[…] many years ago I supported a woman who was a sex worker, and you know, she had past traumas, and she said “I can have sex with anyone, but I can’t be intimate with anyone,” so she had, in her own mind, divided the two to kind of, to say, that she couldn’t have intimate relationships, but she could… (Lori)

Separately, a second participant described the potentially triggering nature of bedrooms and sleeping quarters within domestic environments:

Some people may never sleep in a bedroom again, they could be sixty years old and they won’t sleep in a bedroom because there’s no escape door to get outside from there. (Cheyenne)

Lastly, the third participant elaborated on the triggering nature of domestic environments in more detail, stating:

I do think when we’re talking [about] trauma related to early childhood, and because many of the women and the youth we’re serving have multiple complex early childhood traumas in the form of neglect, abuse, sexual abuse, et cetera, that we
notice they’re triggered by domestic situations and environments. One of the reasons
women who are homeless tell us, that they’re not even sure if they’d take an
apartment if one was found for them, is that living under a bridge doesn’t trigger
them… So it’s the tea towel hanging on the fridge, it’s the fridge, it’s a bed, and if
you’re living under a bridge, you won’t get triggered by those domestic
environments. What are meant to actually be comforting and safe environments […]
are not necessarily so. (Joanne)

Thus, participants acknowledged the ongoing impact of triggers and the potential for re-
traumatization embedded throughout activities of daily living, where impactful stimuli related to
experiences of trauma or adversity are often pervasive and not confined to singular events or
contexts, and therefore contribute to the snowball effect of life course accumulation and may
continue to disrupt functioning, coping, and adaptation beyond finite or singular traumatic or
adverse experiences.

Consequently, participants rejected militarized or romanticized notions of trauma and
PTSD, where they highlighted misguided generalizations of military or first-responder
stereotypes related to trauma:

I also think that—although this may be controversial—I do think that labeling people
and naming trauma as PTSD, because of its association with the military and its
militarized connotation that it tends to be [related to] explosive incidents… It does
not do the diversity and the typical-ness of the experience of trauma justice. I
obviously want PTSD survivors to get the supports they need, and understand and
absolutely agree that firefighters and emergency personnel and military personnel experience PTSD, and that some of that is relevant here, too… But multiple complex gender-specific trauma is not that… (Joanne)

Likewise, another participant commented on the misleading nature and negative impact of media portrayals of PTSD stereotypes:

[…] I think even what you see in the media, when people talk about trauma it’s, you know, first responders, and military, or, it is really sort of boxed in… Maybe if people had a better understanding of trauma and its impact, and just like we’ve done with mental health – reducing the stigma around trauma. So often support groups here will get in discussions about trauma and I’ll say “well tell me about trauma in the media” and the first example that always comes up is Criminal Minds, right? They’ll say “Well there was this Criminal Minds [episode] – the guy had PTSD and, you know, he went on a killing spree!” Well, those are super negative portrayals of trauma, and that’s not really what trauma looks like… (Sarah)

Some participants also attributed stigma surrounding trauma or adversity to the prevalence of misinformation spread through militarized stereotypes and media portrayals that depict socially-acceptable traumatic or adverse experiences as involving “heroics,” where “if you get your trauma the ‘right’ way, […] it’s like approval of your trauma cause, and if they disapprove of your trauma cause, then you’re bad” (Cheyenne). In turn, they recognized that “there’s this notion that trauma only happens to certain people, and it only is certain things,” resulting in the need to “[broaden] that definition for people and [say] ‘we can’t just put trauma in this little box
and stereotype it.” Participants found the militarization, romanticization, and stereotyping of trauma and PTSD to be especially problematic given the under-reported prevalence of trauma or adversity, especially since this prevalence is likely underestimated within narrow or rigid definitions of trauma or adversity, and the presence of stigma fuelled by inaccurate stereotypes may further discourage disclosures of traumatic or adverse experiences and/or help-seeking behaviour among survivors and individuals at-risk.

**Dimensions of diversity.** Participants’ understanding of how individuality, identity, gender identity and/or sexual orientation, diversity, and intersectionality shape subjective experiences further informed their conceptualizations of trauma, adversity, and resilience. Participants universally acknowledged the impact of individuality and individual variability on subjective perceptions of and reactions to trauma or adversity, and in turn, manifestations of resilience. More specifically, they described how prior experiences, personality traits, coping skills, available resources, and context combine to shape resilience, where the factors that promote resilience may vary across different individuals. For instance, one professional stated “I think everybody’s [resilience] is different. I think it’s unique to each person, their tools, their physiology, *everything*, the context of their lives, and what supports they have” (Cheyenne). Similarly, another participant explained that “of course [resilience] can manifest through multiple behaviours, it depends where you are in your life journey, and depends where you are in the social order […]” (Joanne).

Additionally, participants frequently described the impact of trauma or adversity on identity, where such experiences are “an assault on the identity, the body, the spirit, the beliefs,
and the human fundamental rights of an individual” (Joanne), and “can be barriers to accessing your authentic self” (Cheyenne). Conversely, they associated a sense of self or identity with resilience, referring to the importance of “get[ting] to know who you are” (Natasha), knowing “you are your own person” (Marie), distinguishing a sense of self separate from negative experiences, and having an ideal projection of what one wants for themselves. Seven of the ten participants also discussed how motherhood and relational ties to family, as a part of identity and self-concept, functioned as a source of motivation for many female survivors of trauma or adversity.

In addition to individuality and identity, participants considered the impact of cultural, racial, ethnic, and religious diversity in relation to trauma and adversity, describing vulnerabilities related to racism, discrimination, marginalization, oppression, and disenfranchisement associated with minority status, first-generation immigration, cultural heritage, and First Nations, Inuit, or Metis status. However, they also described how resilience among minority status individuals can also be fostered through multicultural assimilation, association with cultural and community groups that encourage diversity and community representation, and the acceptance and promotion of multicultural diverse communities. Similarly, they underscored the impact of gender identity and/or sexual orientation in relation to trauma or adversity, describing the negative impact of power imbalances and loss of agency related to patriarchy, misogyny, and heterosexism; discrimination and exclusion; gendered or sexual violence; and rejection by family or peers among LGBTQ+ individuals. They also noted that experiences of sexual assault have almost become a “normalized” (Sarah) form of trauma or
adversity among young adult females, with males and authority figures being especially triggering for many female survivors of trauma or adversity and individuals at-risk.

Based on their understanding of various dimensions of diversity, participants naturally recognized the implications of intersectionality or instances of double or triple jeopardy (Crenshaw, 1989), highlighting the compounded vulnerability faced by females and/or LGBTQ+ individuals who are also of minority status, living in poverty, and/or are criminalized, homeless, or otherwise marginalized (Balfour, 2012; Esmonde, 2002; Gustafson, 2009). Eight of the ten participants acknowledged criminalization and marginalization as products of “structural issue[s] related to poverty and gender, and increasingly race” (Joanne), emphasizing that the criminal justice system and many social institutions are “destructive systems for poor women, and [for] poor everybody” (Cheyenne). Therefore, participants underscored the need for community and social services to practically conceptualize and foster resilience “in the context of survivors’ economic inequity, their gender inequity, their race inequity, and the real truth about the degree of trauma that they live and experience and are working through” (Joanne).

**Distinction from and coexistence with related constructs.** Participants’ conceptualizations of resilience were also informed by their distinction between resilience and recovery and their observations surrounding the potential for recovery and the coexistence of resilience with distress. Overall, their most salient conceptual distinctions between resilience, recovery, and distress pertained to their observations that resilience frequently co-occurs with distress while also contributing to an ongoing and nonlinear process of recovery, where: i) resilience is roughly equivalent to survivorship, rather than recovery; ii) complete or full
recovery to pre-trauma or baseline states is an unreasonable expectation and likely not possible; and, iii) neither resilience or recovery implies survivors are no longer affected by their experiences of trauma or adversity. All of the participants described how resilience can coexist with distress following trauma or adversity, where “you can be very deeply affected by what’s happened, but then yet have that whole other component to yourself that keeps you thriving and driving yourself forward” (Claire). Similarly, one professional described resilience as “the ability to go forward, but […] there may be aspects of your life that never quite go back to what they were before” (Cheyenne), while another described how “resilience could be just surviving. So, am I still impacted? Absolutely! But am I doing the best I can do, every day? Absolutely!” (Sarah).

Participants also readily distinguished between the constructs of resilience and recovery, with many articulating resilience as a process distinct and pre-existing from, yet contributing to an ongoing process of recovery, where both resilience and recovery are highly nuanced and not synonymous with being unaffected by trauma or adversity:

I think [resilience and recovery] are two different things, in that resilience is almost like a trait that a person has within, where recovery, that’s more of a process… So I think resilience is something that can help with that or contribute to that or make that process a little bit easier, or a little bit more effective or streamlined, but I think having resilience and healing are completely different phenomena. (Caroline)

I think resilience is different [from recovery] in that you can act, and you can go forward, and you can progress. It doesn’t mean you’re not traumatized, it doesn’t
mean you’ll ever be completely over your trauma, it just means that there’s some bounce [back], like you’re kind of able to keep functioning, and keep going, and have some hope going forward… (Cheyenne)

Likewise, a third participant elaborated on how resilience is a pre-existing process distinct from recovery, yet also noted that the process of recovery is also individualized, ongoing, and nonlinear:

Resilience, to me, is almost something that’s pre-existing, something you already had—and it can continue to develop, […] and you can help someone develop those things, but a lot of times they’re already there. It’s hard to picture, for me, what full recovery from trauma is… I think, again, resilience is something that’s always there […] but full recovery from trauma, again, it’s really hard to define because it is such an individual thing, right? (Sarah)

Although three of the ten participants held the belief that complete or full recovery following trauma or adversity is possible, they typically clarified that this referred to a state of no longer being incapacitated by the physical, mental, or emotional pain associated with experiences trauma or adversity. For instance, one professional noted that “healing is different from forgetting” (Sarah), while another explained “the trauma is always going to be there, […] it could be on the backburner of your mind, but absolutely, people can be healed from all of that physical and mental pain” (Marie). However, the remainder of participants held the belief that it is not possible to fully heal or recover from trauma or adversity, in part because recovery is
ongoing and nonlinear with “highs and lows” (Natasha). In turn, most participants regarded recovery as a nonlinear process:

[…] whether it’s trauma recovery or mental health recovery or substance use recovery—it’s a continual journey, so there’s going to be times where you feel like you are ‘recovered,’ and then something might happen and you have a slip, but you have all those skills that you developed through recovery and that slip lasts less time, and is less impactful… Rather than saying it’s this straight line between trauma and recovery, it’s not, right? (Sarah)

[…] you move forward, and you move back—I mean, the hope is that you’re always moving forward, you might come a couple steps back, but you don’t always necessarily go all the way back to step one, so that’s kind of how I always picture [recovery], as very fluid, because I’ve learned that when you think you’ve kind of dealt with everything—well, there’s another lesson to be learned […] (Lori)

Moreover, many participants saw the phrase ‘complete’ or ‘full’ recovery as a misnomer with problematic connotations within a strengths-based perspective, because it implies unrealistic expectations for survivors of trauma or adversity and individuals at-risk to return to pre-trauma or baseline functioning, and ignores cumulative impacts across the life course.

**Theme 3: Continuum of risk and protection.**

The third theme encompassed participants’ conceptualizations of the role of community and social support within a continuum of risk and protection in keeping with prior research on
resilience. Participants understood community and social support as being situated amongst a continuum of individually- and contextually-variable risk and protective factors with the potential for dually-operating risk and protective mechanisms, consistent with seminal research on resilience conducted by Michael Rutter (1987, 2006, 2012, 2013). Participants often found it challenging to identify singular risk or protective factors, mirroring Bonanno and colleagues’ (2010, 2015) conclusion that individual outcomes are shaped by the context in which the trauma or adversity occurred and subsequent exposure to short- and long-term impacts, where singular factors exert little independent influence and the cumulative total of risk and protective factors is more predictive of long-term outcomes. However, participants typically regarded social support from family, friends, peers, professionals, and the community as protective factors, and distinguished social isolation, stigma, and frequent negative social interactions as risk factors.

Participants described how many personal characteristics and environmental factors can exert both risk and protective effects depending on the specific individual and context, where “a lot of the behaviours that people think of as being part of the problem […] are actually part of their solution” (Joanne). Likewise, they described how “certain ways of coping that may have actually been tools to help at one point [are] now barriers to accessing real help and progress in your life” (Cheyenne). For instance, displays of anger, aggression, or negative social behaviours can put survivors and individuals at-risk at greater risk for re-traumatization and negative social feedback, yet enable them to set boundaries, protect or defend themselves, and address basic needs:
a lot of the things that we see as disorders, even, could manifest from a person trying to protect themselves, right? So there’s a lot of things when it comes to individuals who have lived in such a survival mode for so long that they’ve come up with to protect themselves. It could be an attitude, it could be a way of interacting, it could be a way of protecting themselves [...] it could be many different things, but of course, people come up with many creative ways to incorporate their past and what they’ve been through and learn from it in that sense. (Claire)

However, participants also identified various generalized risk factors, including: comorbidity; complex trauma or ACEs; head injury; learned helplessness, ruminative tendencies and the tendency to reject opportunities or help from others; anger, shame, and self-blame; lack of closure in the form of acceptance or forgiveness; and loss of sense of self, identity, or fulfillment. Although some participants’ discussion of the risk associated with comorbidity extended to include comorbid physical and mental health conditions, the majority focused on substance use and chemical dependency as having the potential to exacerbate underlying or pre-existing mental health dispositions, and as a significant impediment to resilience:

[...] it’s hard to support somebody when they’ve got past trauma if they’re currently using substances as well because if they come in and they’re intoxicated, you’re not really going back into any of the trauma, you’re dealing with the moment. (Lori)

Another participant made similar remarks regarding how comorbid substance use or chemical dependency often becomes a primary concern in clinical practice, thereby detracting from the focus on addressing trauma, adversity, and related mental health distress:
[substance use] gives them this sense of numbness that allows them to stop thinking, and so chemical dependency ends up being the focal point, unfortunately, because it can raise another group of issues like criminal activity, abusive relationships… So […] chemical dependency is a huge factor and barrier because we focus on too much of the chemical dependency and not enough on the trauma that they’re actually trying to numb. (Terri)

Participants also recognized complex trauma and ACEs as significant sources of risk or vulnerability, specifically referring to the influence of early childhood environmental factors, and the negative impact of physical, psychological, and sexual abuse during childhood and intergenerational trauma. More specifically, they frequently referenced a strong association between complex trauma and trauma-related mental health distress and behavioural tendencies, including self-injurious behaviour, suicidality, risk-taking behaviour, and deficits in impulse control and risk appraisal.

Likewise, participants identified various personal characteristics as generalized protective factors, including the willingness to seek help, openness with others, and external validation; hope and optimism; use of routines, self-care, and individualized coping strategies; resourcefulness and problem-solving skills; sense of self or identity, agency, and control; self-esteem, self-worth, and self-efficacy; and self-awareness, self-reflective tendencies, and the ability to set healthy boundaries. Although participants noted the protective buffering effects of community and social support following trauma or adversity in keeping with the social-ecological principal of differential impact (Ungar, Ghazinour, & Richter, 2013), they also
described community and social support as positive resource factors for all individuals regardless of exposure to trauma or adversity (Luthar, Cicchetti, & Becker, 2000, Masten & Reed, 2002, and Werner & Smith, 1992, as cited in MacMillan & Violato, 2008). In turn, many participants held beliefs such as “social support is huge for anybody” (Angela), “we all depend on [community and social support] for every aspect of a healthy, balanced life” (Joanne), or that connectedness and support “are critical to human survival” (Caroline). Moreover, they described community and social support as being key to reducing trauma-related mental health distress and fostering a sense of safety, security, and stability, where support from family, friends, professionals, survivors of similar experiences, and community were identified as the most common and readily adaptable protective factors.

Although community and social support were typically understood as protective factors in the face of exposure to trauma or adversity, over half of the participants also described the potential concurrent risk associated with turning to alternative sources of social support such as gangs, fellow substance users, dysfunctional family members, or abusive relationships due to the absence or limited availability of other adequate sources of support:

[...] there’s no safety and belonging, and I think that’s huge, right? Which is why, you know, we see people sometimes going back to a life they may be trying to get out of, specifically because there’s love and support there. How could you ever look down on a person or think differently of them because they’re going back to somewhere where they feel embraced and think they are able to heal? (Claire)
Conversely, participants described the potential for social isolation to also function as a dual risk and protective factor. Although social isolation is largely regarded as a risk factor for PTSD and negative mental health outcomes (Davidson et al., 1991, and Koenen et al., 2003, as cited in Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Bonnano, Romero, & Klein, 2015; DuMont et al., 2007, Jonzon & Lindblad, 2006, and Wright et al., 2005, as cited in Greenfield & Marks, 2010; Littleton et al., 2009, as cited in Miron, Orcutt, & Kumpula, 2014), participants noted that it can also serve as a protective factor in the presence of frequent negative social interactions or stigma, given it may serve as a means to avoid social interactions that further compound or exacerbate trauma-related mental health distress through exposure to triggers, micro-aggressions, and re-traumatization. In turn, participants saw social isolation as precluding social support yet establishing a sense of safety and limiting further exposure to negative social interactions or interpersonal trauma or adversity, where “individuals who isolate [themselves] do it as a safety measure–they’re protecting themselves” (Natasha).

Participants’ observations of the negative impact of social isolation and the need to avoid triggering or re-traumatizing negative social interactions led them to identify stigma as a prominent risk factor, where they described how inaccurate media portrayals, alienation from others, aggressive policing, and over-reactions to trauma disclosures or mental health crises contribute to stigma that promotes social isolation. Although participants acknowledged the potential protective effects of social isolation in the presence of stigmatizing, triggering, or re-traumatizing negative social interactions, they typically regarded the absence of community or social support as a risk factor that exacerbates trauma-related mental health distress and
contributes to feelings of hopelessness, helplessness, worthlessness, stigmatization, invalidation, and reliance on maladaptive or high-risk coping strategies. Consequently, they noted that a lack of community or social support “can actually re-victimize [survivors]” (Terri), and “increase that [sense of] isolation that increases mental health symptoms” (Sarah), especially among vulnerable, at-risk, marginalized, or criminalized populations, where there is a “huge level of stigmatization, particularly when you’re traumatized, exploited, and criminalized for it” (Cheyenne).

**Theme 4: Community and social support.**

The fourth theme describes participants’ understandings of the role of community and social support in fostering resilience based on: i) the influence of the social-ecological environment; ii) their contribution to a reservoir of relational and material interpersonal resources; and, iii) their multidirectional relationship with social competence. Overall, the role of community and social support in fostering resilience among survivors of trauma or adversity and individuals at-risk is most broadly shaped by the social-ecological environment via its direct effects on the availability, quantity, and quality of sources of community and social support. However, the social competence of external social actors further influences the quality of community and social support within interpersonal relationships, where: i) relational and material resources afforded by high-quality interpersonal relationships have the potential to reduce trauma-related mental health distress and promote resilience; and, ii) the social competence of survivors and other social actors interact to result in feedback loops and social
learning mechanisms with the potential to positively influence sense of self-efficacy and communal mastery in a manner that further supports resilience.

**The social-ecological environment.** Participants described how community and social support influence resilience through individuals’ subjective experience of their social-ecological environments as a result of individual- and context-specific person-environment (PxE) interactions (Ungar, Ghazinour, & Richter, 2013). When referring to the potential for PxE interactions, participants discussed how personal characteristics such as genetic or physiological factors and personality traits or temperament shape how individuals interact with and respond to environmental factors including interpersonal relationships, living conditions, and macro-level conditions. Therefore, participants saw resilience as being shaped by both intrinsic characteristics and external factors, where:

> They both go hand in hand, right? When living a life, you get affected by your environment, right? But you also can–to some degree–have control of your environment as well–the people you hang around with, the place you choose to work, and internally, the physical, mental, emotional, and spiritual aspects of self…

(Natasha)

Thus, participants noted considerable difficulty in distinguishing the specific influence of intrinsic individual characteristics and external social-ecological factors on resilience given the potential for complex systemic interactions. It is perhaps due to the inability to distinguish the specific influence of intrinsic characteristics and external factors that participants conceptualized resilience as a three-part construct, given the role of PxE interactions may be overlooked within
the trait-based component, yet is likely better accounted for within the outcome-based component and most heavily reflected by the process-based component that acknowledges the ongoing nonlinear development and manifestation of resilience across the life course.

Moreover, as a result of complex PxE interactions beginning in infancy and early childhood, participants also often found it difficult to distinguish the role of genetic factors versus early childhood experiences, noting that “early childhood environmental factors have a huge influence, but people may confuse those with genetics, and there’s very few things that actually are genetic” (Joanne). Likewise, another participant explained:

I can think of lots of examples where people have grown up in an environment where, in order to survive, they needed to become resilient, and whether that was pre-existing or not, I don’t know […] you may never be able to tell because that’s been their constant, right? And there’s never been a time really where they haven’t had to have that resilience, so where did it come from? (Sarah)

Although participants acknowledged the role of intrinsic individual characteristics such as genes, physiology, or temperament and personality in PxE interactions, the majority explicitly adopted a biopsychosocial perspective (Engel, 1977, 1980) and held beliefs consistent with the social-ecological principle of equifinality that accounts for the disproportionate influence of social-environmental factors (Ungar, Ghazinour, & Richter, 2013). For instance, two participants referenced the example of returning home following in-patient treatment for substance use or chemical dependency to illustrate the disproportionate influence of the social-ecological environment on resilience. One participant explained that “for chemical dependency, they go
away to do treatment on the dependency part and come back to that environment, and nothing has changed, [then] the coping mechanism comes back into play” (Terri), while another similarly stated:

[…] when you go to treatment, and you come out of treatment after six weeks and you go back to your family […] you were the only one that has changed – nobody else in that household has changed, so now you’re going back into an environment that is still the same, right? (Natasha)

In turn, participants largely regarded resilience as being more heavily shaped by the social-ecological environment:

[…] it’s hard to say that any one thing is more influential… you’re living in a world where everything you’ve grown up with is poverty, or crisis, or trauma, and you know, your parents may have been abusive, or you may have not had parents, or may have spent I-don’t-know-how-many years incarcerated… I mean, when it comes to that, it becomes a societal, social-environmental concern along the way, I think more so than the other things, because how do you expect a person to thrive in an impoverished environment, right? (Claire)

Therefore, many participants felt that regardless of the accumulation of individual risk or protective factors, it would be nearly impossible for even the most intrinsically well-adjusted individual to thrive under severely adverse circumstances.
Further to their discussion of the social-ecological environment, participants described the influence of macro-level sociopolitical, socioeconomic, and sociocultural conditions on resilience. All but one participant described how educational attainment, socioeconomic status, employment opportunities, access to safe, affordable housing, and the availability of community resources are all directly shaped by the local, regional, and national political and economic climate. Additionally, they highlighted the compounding negative impact of aggressive or targeted policing, criminalization, and/or prohibitionist attitudes on resilience, noting that “all of these [tendencies] are rooted in centuries of historical oppression” (Caroline) that often penalize and re-victimize survivors and individuals at-risk for trauma-related reactions or behaviours:

[…] the criminal justice system does this so often—penalizing individuals for those coping strategies… And those were all the tools they had in the toolbox. And so now we’re saying that that’s not okay, and we’re going to charge you now and you’re going to have more negative consequences—how is that helping somebody who has already been traumatized? (Terri)

Thus, professionals described many of the structural and systemic issues surrounding race, class, and gender as supporting an “anti-poverty system” (Cheyenne) that criminalizes trauma, adversity, and poverty, where this impact is especially salient to conceptualizations of resilience informed by intersectionality (Balfour, 2012; Crenshaw, 1989; Esmonde, 2002; Gustafson, 2009). Based on their understanding of broader social-ecological influences and interactions between personal characteristics and environmental factors from a biopsychosocial and intersectional perspective, participants concluded that resilience among survivors and individuals
at-risk is supported by social-ecological environments rich in relational and material resources that foster connectedness to others, provide accessible, consistent, and high-quality community and social support, and address basic needs in a manner that fosters a sense of safety, security, and stability.

**Relational and material interpersonal resources.** Participants expanded on how resilience is shaped by community and social support through the creation of a reservoir of relational and material interpersonal resources, in keeping with Hobfoll, Stevens, and Zalta’s (2015) conservation of resources (COR) theory of resilience. Participants described both the benefits and caveats associated with support from family, friends, and professionals, emphasizing that supportive family and friends are key to enabling adaptation and resilience during times of crisis, yet recognized the triggering nature of family dysfunction and the prevalence of complex trauma and ACEs involving caregivers, family members, and relatives. Alternatively, some of these participants highlighted the benefit of selectively choosing supportive friends as opposed to being born into a dysfunctional family situation, especially given that friends or peers may be more apt to provide non-judgemental support:

I think a lot of the times really what youth are looking for is just that non-judgemental support, and they’re not necessarily looking to be told what to do, but just a space to put that til they’re ready to do something with it. And there’s a big difference in that, and I don’t necessarily think that all supports are like that… So being able to allow that person, being a support that allows that person the space to do what they need to do for them, but still continues to be supportive. That’s a, a fine
balance… And I think that’s why we often hear about youth going to their friends for support, right? Because that friend is going to be the person who’s not going to judge you, and not going to tell you what to do—they’re going to listen! (Sarah)

However, other participants acknowledged the reciprocal nature of interpersonal relationships, and described support from family and friends as being “skewed” and “emotional” within a “two-sided relationship” (Caroline), albeit typically well-intentioned. Alternatively, participants referred to support from professionals as an opportunity for more objective and trauma-informed insight that is solely focused on the specific needs and experiences of survivors and individuals at-risk, yet also recognized challenges associated with navigating community and social services, issues related to service accessibility, availability, and eligibility, and clashes with service providers and lacking professional competencies. Despite the potential shortcomings or challenges associated with various sources of support, participants concluded that survivors of trauma or adversity and individuals at-risk require a complimentary network of supportive relationships to talk openly about their experiences without judgement or external expectations:

The reality is that if your core supports are professionals, those aren’t people who are always going to be there for you, right? So that ability to have sort of different people in different realms, whether it’s a teacher at school, or your best friend, or a pastor at church… You need to have a variety of ‘safe’ people. And it doesn’t necessarily mean that all of those people know all the details about your life, but each person can provide different elements of support to you, right? (Sarah)
In turn, participants emphasized that within this complimentary network of support, one source of support is not superior to another, given they afford a diverse array of relational and material interpersonal resources that combine to support resilience.

Participants also noted that regardless of the source of support, relatable support, peer-to-peer support, and support from those with shared experiences is especially beneficial to survivors and individuals at-risk. Many participants disclosed familiarity with research indicating that peer support is one of the strongest predictors of positive mental health outcomes following trauma or adversity, especially when referring to youth, substance use and chemical dependency, sex work, and sexual assault. Likewise, they frequently observed notable improvements in psychosocial wellbeing and mental health associated with “meeting people who have been in similar situations” (Cheyenne), where relatable support from peers helps survivors and individuals at-risk feel less alone because these peers “get it” and “understand what I’m going through” (Lori). Furthermore, some participants described how living in a high-quality, trauma-informed residential care setting can create “its own community of support” (Joanne) by establishing “a community of people who are at all different stages of healing” (Caroline). Overall, participants concluded that relatable support from peers or those with shared experiences can offer real, concrete examples of resilience and life beyond trauma or adversity.

Participants additionally identified sociocultural or community engagement and recreation as a source of community and social support that fosters resilience, where the benefits of such support are rooted in shared enjoyment, meaning, fulfillment, and group affiliation, inclusion, and connectedness. Participants described how resilience is influenced by the “overall
connectedness” (Sarah) of survivors and individuals at-risk to their communities, where affiliation with religious or cultural groups can offer support and a sense of belonging via socialization with like-minded individuals. Similarly, participants noted that involvement in community recreation, volunteer work, activism, and hobbies can also enhance a sense of meaning and fulfillment that positively influences identity formation and resilience. For instance, some participants described how female residents of a local community-based residential shelter enjoyed watching movies and listening to music as a group, and how companionship between co-residents reduced mental health distress. Separately, another participant noted more generally that:

It seems if [survivors or individuals at-risk] have something, even if it’s a job, or a really solid goal with school, or an attachment to an extracurricular activity, something that they can almost hang on to as a hope or as a distraction— it seems to increase their ability to cope with the effects [of trauma or adversity], right? Versus clients who may be very isolated and not have a lot of social contacts or external supports… (Sarah)

Therefore, participants recognized that sociocultural or community engagement and recreation may not directly provide survivors and individuals at-risk with trauma-informed support, yet may indirectly support resilience by providing opportunities to foster communal belonging, connectedness, and positive, supportive interpersonal relationships that contribute to a complimentary network of support.
Conversely, participants typically understood social isolation and a lack of community or social support as the loss of relational or material interpersonal resources that foster resilience. Moreover, they noted that a lack of community or social support may lead some survivors and individuals at-risk to seek out interpersonal resources in a maladaptive or high-risk manner that leads to further adversity or re-traumatization. Furthermore, they described how high-quality community and social support following trauma or adversity:

[…] creates a sense of safety, and that’s—when you look at trauma recovery—that’s what the goal is, is to feel safe within yourself and your environment again, and the more connections we have, the safer the world is going to feel. (Sarah)

Similarly, another participant explained that “feeling safe enables a person to perceive something as positive as opposed to seeing it as the automatic threat that’s going to impact you” (Claire).

Consequently, participants emphasized safety, security, and stability within interpersonal relationships, and thus the security and stability of the relational and material resources afforded within them as a basic need among survivors and individuals at-risk following trauma or adversity.

Social competence. Participants understood the influence of community and social support on resilience, as well as the quality of relational and material resources within interpersonal relationships, as being shaped by the social competencies of various external social actors present throughout the social-ecological environment. When referring to the social competencies of survivors and individuals at-risk, participants noted that exposure to trauma or adversity can: i) result in trauma-related mental health distress that negatively impacts social
competence; ii) result in deficits in social competence due to exposure at key developmental turning points; and, iii) lead individuals to behave in an assertive, aggressive, confrontational, or otherwise unfavourable manner as a coping or self-defence mechanism. For instance, one participant explained:

[…] when somebody’s experienced trauma, if they, you know, sometimes they’ll be more aggressive, more assertive, be yelling and screaming, but it’s not because they’re actually angry, it’s because they’re hurt. There’s a lot of grief people can carry around with them, which eventually can turn into more anger, or into self-harming, whether it’s substance use self-harm in other ways… But we have to remember that those are all pieces of the trauma, the grief, and all of those emotions that people just sometimes bury… (Lori)

Likewise, another participant described how survivors and individuals at-risk may not conform to ‘victim’ stereotypes, and may display unfavourable social behaviours as a result of prolonged exposure to trauma or adversity, where these behaviours inadvertently promote negative feedback from other social actors:

[…] it doesn’t always look ‘pretty’–I don’t know if that’s the right way to say it… It doesn’t always look like someone is a ‘victim,’ like a stereotypical victim, because this person has had to survive this long, so the personality characteristics that a person is displaying may not be favourable to some people and it may be really hard to interact with that person. (Claire)
This participant further elaborated on the challenges faced by survivors and individuals at-risk affected by deficits in social competence:

[…] it becomes really hard for a person to function in a communal setting when they’re not aware or seemingly socially conscious. It just makes life so much harder for them, right? I’m not saying that that person should change, or that they need to change everything about them, because that’s the way they are […] for somebody who’s exhibiting undesirable social traits, it just makes it so hard for them to get along with people, to even eat a meal with people, right? (Claire)

In turn, many participants recognized trauma-related deficits in social competence as not only being influenced by exposure to trauma or adversity, but also being heavily influenced by negative social feedback that further reinforces problematic interpersonal interactions. Again, the same participant eloquently explained how such negative social feedback impacts survivors and individuals at-risk:

[…] then they keep on getting this push-back from everybody around them all the time, and then it becomes so difficult to just live day-in and day-out […] It just becomes challenging for that person, and I wonder then how that affects them, how are they perceiving that? So somebody might be perceiving that as just normal, but then it might be adding to their trauma, right? That the world is not a hospitable place, that the world is a dangerous place, and that all of this just keeps confirming it, right? It’s hard… (Claire)
Although some participants identified various personal characteristics that influence social competence such as temperament, personality, and communication style, the vast majority emphasized how self-awareness and self-reflection contribute to social competence among survivors and individuals at-risk in a manner that supports resilience and prosocial behaviour. Yet instead of trauma- or adversity-related deficits in social competence remaining the core focus, participants equally emphasized the impact of parental or familial competence on resilience among survivors of trauma or adversity and individuals at-risk. Eight of the ten participants described how family and caregivers are frequently involved in traumatic or adverse experiences, including their role as perpetrators as well as in enabling maladaptive or high-risk patterns of behaviour, where “toxic” family dynamics can “keep people stagnant” or “tied down” (Natasha), and families can unintentionally “get caught in patterns of learned helplessness” (Lori). Many participants also recognized that “unfortunately the most severe forms of trauma are incurred [via] family” where “breaking that familial trust, for lack of describing it accurately, is the worst form of trauma” (Caroline).

Additionally, participants acknowledged the “re-traumatizing” (Sarah; Caroline) “re-victimizing” (Terri) and “stigmatizing” (Cheyenne) nature of negative social interactions and social isolation for survivors and individuals at-risk. Participants described how the frequency and severity of such interactions erodes a sense of trust, safety, and/or willingness to disclose traumatic or adverse experiences, can contribute to maladaptive or high-risk coping behaviours, and ultimately shapes behaviour via social learning. Five of the ten participants relied on a basic
first aid metaphor to illustrate the need for mental health literacy and first aid as components of basic social competency among external social actors:

Just as most people know that, you know, a bleeding wound needs pressure, most people should know that someone [exhibiting erratic behaviour or mental health distress] is likely a trauma survivor and actually just needs space and to not be overwhelmed and to not be told what to do, and to just hold some safe space for them and move people back… (Joanne)

In turn, participants advocated for mental health literacy, knowledge of mental health first aid, trauma-informed psychoeducation, a basic level of kindness and compassion, and the reduction of judgement and stigma as means enhance the social competence of external social actors.

Perhaps most notably, participants underscored how the social competence of external social actors shapes the quality of interpersonal relational and material resources, and thus the impact of community and social support on resilience through reciprocal feedback loops and social learning mechanisms. Participants noted that just as trauma-related deficits in social competence among survivors or individuals at-risk may evoke negative social feedback from others, deficits in social competence among external social actors further reinforce the propensity for problematic social interactions that are triggering or re-traumatizing for survivors and individuals at-risk. Thus, participants described how the social competence of external social actors, survivors, and individuals at-risk consequently interact in a reciprocal multidirectional manner to influence each other through the creation of feedback loops and social learning mechanisms that can either contribute to resilience by promoting a sense of self-efficacy and
communal mastery, or contribute to recurrent re-traumatization that reinforces social isolation and deficits in social competence among survivors and individuals at-risk:

[…] whether that’s from caregivers, or bullying in a school environment, or in a series of relationships—that because I haven’t healed from one trauma I can’t form positive relationships… Those negative interactions can be… That’s where we start talking about that snowball that we see so often. So, [clients often say] “you know, this happened when I was seven, and I never really told anyone and now I’m eighteen and between seven and eighteen all these little things have happened…” that tend to be as a result of negative social interactions or negative supports […] (Sarah)

When referring to the role of social learning, participants emphasized both the positive and negative effects of social modeling of learned behaviours from parents, caregivers, friends, peers, and professionals. Multiple participants described their attempts to model resilience and adaptive coping in their clinical interactions with survivors and individuals at-risk, although they recognized the tendency for individuals to “model what they’ve known” (Cheyenne), where the behaviour of parents or caregivers often serves as a model to either emulate or avoid:

[…] if you saw your parents react to similar situations, it would help you in a way too, because you’ll know either a) that’s how I should react to this kind of situation, or, b) I don’t ever want to react like that at all, I want to have stronger coping mechanisms than they did […] (Angela)

Overall, participants concluded that successfully navigating the external world and engaging in positive social interactions with socially competent external actors provides opportunities for
survivors and individuals at-risk to exercise practical and social skills in a manner that positively reinforces self-efficacy, communal mastery, and functional or adaptive learned behaviours that contribute to resilience.

**Theme 5: Service & approach considerations.**

Finally, the fifth theme identified through the hybridized thematic analysis summarizes participants’ service and approach considerations based on their conceptualizations of resilience and the role of community and social support. Overall, participants advocated for community and social services that were designed and implemented in a manner consistent with trauma-informed and strengths-based resilience-building approaches. Yet in addition to these considerations, participants’ also highlighted prevention and management strategies for professional burnout and the promotion of professional resilience.

**Service considerations.** Participants’ advocated for a continuum of care comprised of complimentary trauma-informed multidisciplinary services for survivors and individuals at-risk that acknowledge the pervasive impacts of mental health, trauma, and adversity on basic aspects of daily life and address multiple domains of functioning and wellbeing. Within this continuum of care, participants highlighted the importance of practical supports related to housing, basic needs, advocacy, and criminal justice supports, noting that mental health concerns often become secondary considerations during times of acute crisis, where addressing basic needs is especially imperative. However, they also recognized poor mental health as a barrier to accessing or addressing basic needs, and in turn, typically sought to address mental health concerns in a manner that enables survivors and individuals at-risk to meet their own basic needs and address
trauma-related distress following stabilization of the crisis. As a result, participants often engaged in general advocacy related to helping their clients acquire basic needs and housing, navigate healthcare and social service systems, maintain sobriety, exit the criminal justice system or comply with conditions of release, and return to activities of daily living. Notably, half of participants proposed that the first intervention upon arrest should be trauma-informed counselling, where they argued that addressing the root of maladaptive or high-risk behaviour through a trauma-informed, versus punitive approaches, would be more cost-effective and beneficial to the wellbeing of both the community at large and survivors or individuals at-risk.

Participants ultimately sought to provide trauma-informed mental health supports and crisis intervention concurrent with practical supports and advocacy. While working to address basic needs, participants attempted to address the effects of trauma or adversity across various domains of functioning within one-on-one discussions, residential care settings, and informal “street counselling” (Lori) while completing activities of daily living with their clients, such as attending medical appointments, food banks, and grocery stores; running errands; and helping with activities of daily living, such as making phone calls, appointment scheduling, or budgeting. Additionally, participants often leveraged gender-specific and peer-to-peer supports to help normalize discussions surrounding trauma and mental health in a manner compatible with gender norms while capitalizing on support from like others. Many of these same participants frequently referenced the success of peer support groups such as Alcoholics Anonymous, Al-Anon Family Groups, or Narcotics Anonymous.
However, seven of the ten participants also remarked on the need for timely access to trauma-informed community and social services. More specifically, participants noted a need for mental health and crisis intervention services on short-notice, and criticized the threshold for support from crisis services based on reports from clients that such services often fail to address trauma-related mental health distress that is acute and severe yet does not meet agency criteria for the dispatch of crisis intervention teams, immediate referrals, or in-patient admission. Additionally, they readily identified the need to capitalize on critical windows for intervention and promote client-centred care strategies and care continuity, based on observations that “for a lot of people, there seems to be this real window where everything else is almost going well enough that they feel like they can enter into [treatment]” (Sarah). At least four participants disclosed frequently encountering instances where survivors and individuals at-risk seek out trauma-informed mental health services, yet encounter waitlists or limited program availability, only to find that they are no longer willing or able to take part once the service becomes available. Alternatively, three other participants noted the utility of well-designed, trauma-informed residential care settings where high-quality, readily available mental health support would not typically be available outside of this setting. Thus, some regarded residential care settings as safe havens for survivors and individuals at-risk that can provide what may be their first opportunity to focus on their own wellbeing with the necessary trauma-informed resources, in keeping with a sanctuary model of complex trauma treatment within residential care (Bloom & Farragher, 2013, as cited in Kagan, Henry, Richardson, Trinkle, & LaFrenier, 2014; Bloom & Farragher, 2010, as cited in Kagan & Spinazzola, 2013), and the role of turning points and the

Finally, participants also encouraged collaboration with stakeholders and community partners, explaining how the involvement of external community members or groups in programs and services contributes to a sense of community, connectedness, and inclusivity. Likewise, they highlighted how community outreach initiatives involving psychoeducation, mental health literacy and first aid, suicide awareness training, and awareness initiatives regarding trauma or adversity within existing hubs and community groups all normalize mental health and decrease stigma in a manner that improves the accessibility and quality of naturally-occurring sources of community and social support within the social-ecological environment. However, virtually all participants identified the need for additional resources—namely, funding to improve service availability.

**Strengths-based approach considerations.** Participants regarded resilience as an intuitively understood concept naturally threaded throughout psychology, social work, and social service work practice. Participants saw their role in community and social services as being situated at the level of addressing basic needs, rather than fulfilling a self-actualization component in a hierarchy of needs, and viewed fostering resilience as the core focus of their work with survivors and individuals at-risk. In turn, they described how “we all look for resiliency in people” (Natasha) and are “always looking for protective factors as a way of understanding risk and knowing what a person has to protect them” (Claire), often referring to the recognition of existing resilience as a spiral, where “the more you talk about people having it,
the more you believe they have it, the more they do” (Joanne). Participants’ intuitive understandings of resilience and their attention to recognizing existing resilience among survivors and individuals at-risk naturally incorporated their understanding of resilience as a three-part construct, where they acknowledged that resilience cannot be conceived as a singular trait or outcome separate from the process of resilience evolving over the life course, especially given significant individual- and contextual-variability in the development and manifestation of resilience.

Additionally, participants highlighted various professional competencies and continued education as being essential to trauma-informed strengths-based work with survivors and individuals at-risk. Many took personal initiative to familiarize themselves with research on trauma, mental health, and resilience, and frequently engaged in continued education and/or workplace training initiatives regarding trauma-informed care, resilience-building and strengths-based approaches, substance use and chemical dependency, sexual assault, human rights, disability accessibility, inclusion, anti-oppression, homelessness, human-trafficking, and the recent opioid epidemic. Likewise, they described self-awareness, awareness of potential trauma reactions and triggers, empathy, and non-biased or non-judgemental language and behaviour in micro-interactions as core professional competencies, where:

[…] what’s important for clients is how it translates into behaviours, because you can articulate beliefs and values all you like from a perspective that is strength- and asset-based, but if in your interactions with clients you […] assume expertise, and assume
actually incompetence as part of that dynamic [...] that will erode any trust that they have [...] (Joanne)

Within their efforts to avoid biased or judgemental language and behaviour in micro-interactions with survivors and individuals at-risk, participants paid careful attention to the avoidance of triggers and triggering language by using strengths-based language in framing adaptive and maladaptive behaviours. For instance, one participant eloquently described the need to ensure survivors and individuals at-risk understand that professionals recognize “you’re struggling with something, not ‘we’re struggling with you,’” while another elaborated more generally on the importance of empathy and awareness of potential trauma reactions among community and social service professionals:

[…] it does take a level of awareness from staff that no one person is going to respond the same way to being traumatized or going through a crisis or going through stress and distress […] But I think that just understanding where that person is coming from, and having knowledge and education on the fact that this person has been through a tremendous amount in their life, and whatever way it’s coming out in this given moment isn’t a reflection of how they think of you in this moment in time, but of what they’re going through. (Claire)

In turn, participants recognized the need to address personal biases and their own histories of trauma or adversity in order to remain open, non-judgemental, patient, and empathetic in their clinical interactions with survivors and individuals at-risk.
Within participants’ discussions of professional competencies, many referred to lived experience as an invaluable tool for rapport-building. Five participants disclosed their own personal histories of trauma or adversity, which they regarded as heavily influential in their decision to enter the field of community and social services. While they acknowledged rapport can be naturally fostered over time, many leveraged their lived experience to establish rapport with survivors and individuals at-risk, connect with them, and make themselves more relatable. For instance, one participant described her rationale for disclosing her lived experience when working survivors and individuals at-risk:

[…] so depending on who the person is, sometimes I will disclose my own history, when relevant, of course… You can sometimes show people when they come out about their struggles that “okay, I’m not alone.” It’s that sense of connection… (Lori)

Another participant provided a more detailed explanation as to how lived experience can serve as a resource for professionals in clinical practice:

I strongly believe in life experience as a resource–this is my personal opinion–but life experience speaks volumes to understanding […] it doesn’t have to be the exact same experience […] But life experience enables understanding, as well… I mean, you don’t need life experience, you can have all of the academic knowledge–great! But, life experience, it also–there’s empathy in a way that–it’s totally different. And clients? They know… Clients are something else, they know when you’re not being real […] (Natasha)
However, participants also emphasized the extremely sensitive nature of personal disclosure—especially first-time disclosures of trauma or adversity. Like other forms of acute trauma-related mental health distress, such disclosures require an even deeper level of professional awareness and a distinct set of professional competencies focused on holding safe space rather than clinical intervention or resilience-building:

[...] a safe way of holding space—you know, our inclination as service providers is to think we can help and to want to help at all costs. Holding space is hard for us to do as professionals, but in the moment, in particular, that is actually your job, and it is the job to do, is to hold safe space for someone to [...] you know, I’m just here for you while you feel this. (Joanne)

Moreover, many participants noted that having survivors and individuals at-risk recount their experiences—often as part of intake procedures—can be re-traumatizing, contribute to an unwillingness to engage with community and social services, and is often not necessary for the provision of trauma-informed psychosocial support. Instead, participants were inclined toward a willingness to “talk around the trauma” where “we can talk about how this is impacting you without you having to retell that story and become re-traumatized by it” (Sarah). This same professional elaborated further on the need to allow survivors and individuals at-risk to self-identify experiences of trauma or adversity, as well as sources of strength and resilience:

[...] obviously as professionals we have this base knowledge of what trauma and resilience mean, but one of the worst mistakes that we can make is trying to define that for them, right? To say to them “You’re a resilient person because of x, y, z” so...
yes that’s true, it’s great to identify those strengths, but to say “oh, this is not trauma”
and “this is”—we can’t do that, right? It really has to be what their perception is of
what’s happening, and we can use the language around it and give words to it, but
they, in the end, need to buy it and believe it… And self-identify it. (Sarah)

Thus, participants strongly encouraged self-identification of histories of trauma or adversity at
the discretion and readiness of survivors and individuals at-risk as a means to account for the
subjectivity of lived experience, avoid intrusive questioning while identifying individualized
needs, and enable survivors and individuals at-risk to assert their agency by giving voice to their
histories and survivorship.

Participants often incorporated self-reflective, creative, mindfulness, and arts-based
activities as program components or tools within their clinical practice to encourage self-
expression, grounding, and self-soothing techniques. They also described strategies to foster
hope, sense of self or identity, and perspective or insight among survivors and individuals at-risk
to “change ideas or realities or thoughts about what life can look like” (Cheyenne). For instance,
one participant metaphorically explained that as “keepers of hope” (Lori):

We kind of, when somebody’s in that dark place and that moment, we’re the ones
who try to remind them what they’ve accomplished, where they’ve come from and
how much they’ve done, and to give them that hope that they can keep going
forward… (Lori)

To foster hope and help survivors and individuals at-risk gain greater perspective or insight,
participants often sought to leverage existing resources or protective factors through the self-
identification of contextually-transferable strengths or assets. For example, one participant summarized:

[…] as you go through exercises and planning and discussions, you always elicit and foster and nurture and encourage self-reflection on “what I’ve done that worked before,” you know, “what has worked for me?” because there’s always something that worked for you. (Joanne)

Leveraging self-identified resources and personal assets enabled participants to work with survivors and individuals at-risk to establish realistic self-determined plans and goals that are reasonable and achievable based on individual needs, characteristics, circumstances, existing resources, and personal strengths. Participants frequently relied on this approach as means to promote basic competencies and foster a sense of self-efficacy, agency, and control among survivors and individuals at-risk that explicitly recognizes the value of survivorship and personal expertise relevant to defining one’s own subjective reality, needs, strengths, goals, and wellbeing. Participants ultimately recognized survivors and individuals at-risk as experts in their own lives, where high-quality therapeutic relationships with competent trauma-informed community and social service professionals can afford support that compliments their inherent resilience and survivorship.

Lastly, in addition to fostering a sense of agency and control by leveraging self-identified resources and assets to address self-determined needs, plans, and goals, participants also understood a sense of agency and control as being closely tied to a sense of self or identity. Consequently, participants emphasized the importance of a sense of self or identity related to
helping survivors and individuals “find their voice” (Natasha) in vocalizing their needs and setting boundaries. Many sought to help survivors and individuals at-risk shift from a sense of “being controlled by” to “having control over” (Caroline) their experiences, circumstances, and environment in a manner that enables them to exercise autonomy, “take back their power” (Natasha), and distinguish a sense of self separate from negative experiences. However, participants acknowledged the difficulty in establishing a sense of agency or control among survivors and individuals at-risk, especially in the absence of a sense of safety, security, and stability as a result of early childhood experiences, their current context and risk and protective factors, and/or the presence of recurrent triggers or re-traumatization. Thus, they also understood the need to “create a safe environment” and “create as much control over the environment as possible” (Joanne), while promoting “safe space within relationships” (Claire) as being fundamental to fostering a sense of agency and control among survivors of trauma or adversity and individuals at-risk beyond leveraging resources or assets and fostering a sense of self or identity.

**Considerations for professional burnout.** Distinct from their trauma-informed strengths-based approach considerations, many participants discussed the impact of professional burnout along with resilience-based prevention and management strategies. Participants referred to both compassion fatigue and a clinical syndrome of professional burnout associated with physical fatigue and depersonalization, with six of the ten participants having disclosed having experienced one or both phenomena. Additionally, participants described how vicarious trauma, personal histories of trauma or adversity, and external events in their personal lives contribute to
the accumulation of stress and impact professional competency in the workplace. Likewise, they described the difficult nature of their work, where seeing others in mental pain, suffering, or distress becomes emotionally draining, exhausting, and can erode capacities for professional compassion and lead to the depersonalization of clients. Furthermore, some participants described their passion for their work despite its consequences to their own wellbeing, only to find a lack of support from family and friends who disagree with their commitment to their work given its toll on their health. Notably, some participants also described how empathy can contribute to both professional competency and burnout or compassion fatigue, and the need to separate emotional versus cognitive empathy along with the liberal use of self-care strategies.

Participants’ self-care strategies ranged from making time for personal hobbies or relaxation, meditation and mindfulness, debriefing, seeking social support from friends, family, and colleagues, and engaging in formal counselling on an as-needed basis. Participants viewed self-care as being necessary on an ongoing basis even in the absence of acute stressors, and as especially imperative during times of heightened personal or professional workloads, following critical incidents, and in the presence of personal histories of trauma or adversity triggered by vicarious professional experiences. Participants’ self-care strategies were highly individualized and grounded in the notion of caring for caregivers to support their provision of competent trauma-informed care to survivors and individuals at-risk. Additionally, six participants referred to the promotion of professional resilience, where a self-reflective process of finding value and meaning in one’s work by reframing the positive impact on others to enhance a sense of
professional self-efficacy despite fatigue or exhaustion can serve as a means to combat professional burnout and compassion fatigue.

**Summary**

The five themes identified through the hybridized thematic analysis were distinct across the data set, yet many of their characteristics and sub-themes overlap and are closely intertwined. Consequently, these results suggest practical conceptualizations of trauma, adversity, resilience, and community and social support cannot be independently understood in and of themselves, given their interconnected relationship and the degree to which they are entrenched in the social-ecological environment. Given the consistency of these findings with prior research on resilience, the remainder of this thesis grounds these results in the literature reviewed and summarizes relevant limitations, conclusions, and recommendations.
Chapter 5 – Discussion

Grounding the Findings in Existing Literature

In-depth interviews with a purposive snowball sample of ten community and social service professionals provided a robust data set for analysis that enabled the construction of comprehensive themes to articulate professional conceptualizations of resilience and the role of community and social support along with subsequent service and approach considerations. The first and second themes pertaining to resilience as a three-part construct and secondary conceptual considerations for resilience, respectively, respond directly to the first research question regarding professional conceptualizations of resilience. Likewise, the third and fourth themes regarding the continuum of risk and protection and community and social support correspond to the second research question regarding the role of community and social support in fostering resilience. Finally, the fifth theme encompassing service and approach considerations addresses the third and final research question of how community and social services can foster resilience among survivors of trauma or adversity and individuals at-risk.

These five themes were closely interconnected despite forming distinct topic-based categories within the analysis, wherein multiple characteristics and sub-themes combine and overlap. Most notably, participants’ conceptualization of resilience as a three-part construct was further reflected within their understanding of the social-ecological environment, the role of community and social support, and their service and approach considerations. More specifically, participants’ conceptualizations of trait-, outcome-, and process-based components of resilience and their secondary conceptual considerations regarding definitions of trauma and adversity,
dimensions of diversity, and recovery and distress were embedded within their understandings of: i) cumulative person-environment (PxE) interactions and interactions between risk and protective factors; ii) the impact of relational and material interpersonal resources and reciprocal feedback loops shaped by social competence within patterned social interactions; and, iii) their focus on facilitating self-identification, self-determination, and fostering hope, perspective, sense of self or identity, sense of agency or control, and sense of safety, security, and stability within their strengths-based approach considerations. Additionally, a number of characteristics within these five themes share similarities with findings from the systematic review of recent literature as well as seminal research on resilience, beyond the use of deductive a priori codes within the hybridized thematic analysis. Although there were somewhat fewer consistencies amongst participants’ service and approach considerations, these inconsistencies may reflect the scope of the literature reviewed and may be useful in identifying gaps in research or regional trauma-informed community and social services.

**Conceptualizing Trauma, Adversity, & Resilience**

Participants’ conceptualizations of resilience as a three-part construct comprised of trait-, outcome-, and process-based components appeared to reflect the theoretical and empirical debate surrounding whether resilience is best conceptualized as a relatively stable trait, an outcome following trauma or adversity, or an ongoing process (Banyard & Williams, 2007; Bonanno, Brewin, Kaniasty, & La Greca, 2010; Bonanno, Galea, Buccarelli, & Vlahov, 2007; Bonnano, Romero, & Klein, 2015; Hines, 2015; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). Notably, participants’ observations of the prevalence of resilience among survivors and
individuals at-risk seemed roughly congruent to prevalence rates in resilience research that
describe resilience as a relatively common trajectory (Bonanno, Brewin, Kaniasty, & La Greca,
2010; Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Bonnano, Romero, & Klein, 2015;
Goodman, 2015; Miron, Orcutt, & Kumpula, 2014; Roysircar, Colvin, Afolayan, Thompson, &
Robertson, 2017). Likewise, the notion of resilience as a potential silver-lining following trauma
or adversity resembles findings that successful coping with stress or adversity may exert steeling
effects via stress inoculation (Rutter, 1987, 2006, 2012, 2013). However, although participants
identified resilience as a prevalent outcome and frequently referred to it as a trait in and of itself,
they most often described resilience as a nonlinear process—developing over time and waxing
and waning with natural highs and lows over the life course.

Additionally, participants’ heavy reliance on definitions of trauma and adversity to
inform conceptualizations of resilience led them to describe a snowball effect within the life
course accumulation of trauma or adversity. Participants’ attention to the accumulation of
traumatic or adverse events, re-traumatization, and triggers was consistent with a life course
perspective of resilience, risk, and protection that accounts for the cumulative impact of chronic
stress or adversity and natural turning points across the life course that impact individual
circumstances, opportunities, and the availability of community and social support (Felitti, et al.,
& Johnson, 2004). Moreover, participants readily distinguished resilience from recovery, yet saw
these concepts as being intertwined through the influence of resilience on nonlinear trajectories
of concurrent distress and recovery, in keeping with findings illustrating the ongoing nature of
recovery and the coexistence of PTS and maladaptive tendencies with adaptive functioning and resilience (Banyard & Williams, 2007; Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Leipold & Greve, 2009, as cited in de Terte, Stephens, & Huddleston, 2014; Goodman, 2015; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012; Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017).

Participants were also attentive to the impact dimensions of diversity on resilience, likely as a result of the sample population recruited for this study, given many of the professionals interviewed were affiliated with community and social services that provide supports to survivors and individuals at-risk who are also facing criminalization and/or various forms of marginalization or stigmatization. Participants often referred to ongoing abuse, discrimination, exclusion, and social isolation faced by Indigenous peoples and LGBTQ+ individuals, along with the compounding effects of poverty, housing insecurity, and criminalization related to intersectionality (Balfour, 2012; Crenshaw, 1989; Esmonde, 2002; Gustafson, 2009). Despite criticisms that the clinical concepts of PTS and PTSD are culturally-disembodied and blind to sociopolitical or sociocultural contexts, participants’ understanding of the relationship between dimensions of diversity and the propensity for exposure to broader forms of trauma or adversity aligns with conceptualizations of historical trauma, intergenerational trauma, race-based traumatic stress, and institutional betrayal trauma as subtypes of trauma or adversity, as well as the negative impacts of colonization, government assimilation practices, and institutionalized power imbalances within an anti-oppression framework (Alessi, 2016; Goodman, 2015; Hobfoll, et al., 2009; Lykes, 2013; Overstreet & Mathews, 2011; Reinschmidt, Attakai, Kahn,
Whitewater, & Teufel-Shone, 2016). Likewise, participants’ descriptions of cultural- and contextual-variability in manifestations of resilience and trauma-related mental health distress as a result of socialization, norms and expectations, and cultural, spiritual, or religious teachings was also consistent with findings from resilience research with diverse populations (Alessi, 2016; Lykes, 2013; Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016; Somasundaram & Sivayokan, 2013).

**Conceptualizing the Role of Community & Social Support**

Participants conceptualized the role of community and social support within a continuum of risk and protection characterized by the potential for dually-operating risk and protective mechanisms. More specifically, participants noted that although social isolation is frequently recognized as a risk factor for unfavourable mental health outcomes following trauma or adversity (Davidson et al., 1991, and Koenen et al., 2003, as cited in Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Bonnano, Romero, & Klein, 2015; DuMont et al., 2007, Jonzon & Lindblad, 2006, and Wright et al., 2005, as cited in Greenfield & Marks, 2010; Littleton et al., 2009, as cited in Miron, Orcutt, & Kumpula, 2014), social isolation can also serve as a protective factor in the presence of recurrent triggers, re-traumatization, or negative social interactions that are distressing or stigmatizing. Likewise, despite the protection afforded by community and social support, some survivors and individuals at-risk may turn to alternative maladaptive or high-risk sources of support in the absence of high-quality community and social support, thereby increasing the likelihood of further adversity or re-traumatization. Participants’ articulation of the dual risk and protective effects associated with community and social support
and social isolation paralleled Rutter’s (1987, 2006, 2013) frequent assertion that factors typically conceived as high-risk may actually exert significant protective effects based on the sum of other factors and circumstances. Moreover, participants often found it challenging to identify singular risk or protective factors, mirroring Bonanno and colleagues’ (2010, 2015) conclusion that individual outcomes are shaped by the context in which the trauma or adversity occurred and subsequent exposure to proximal and distal impacts, where singular factors exert little independent influence and the cumulative total of risk and protective factors is more predictive of long-term outcomes.

Participants’ conceptualizations of the role of community and social support within a continuum of risk and protection naturally led them to describe the role of such support within resource-rich environments and the impact of the broader social-ecology. Participants elaborated on the impact of macro-level sociopolitical, sociocultural, and socioeconomic conditions on resilience, specifically noting the negative impact of systemic oppression, racism, and discrimination implicit within prejudicial laws, aggressive policing tactics, and social institutions that perpetuate the negative impacts of colonialization, government assimilation practices, and institutionalized power imbalances (Alessi, 2016; Goodman, 2015; Hobfoll, et al., 2009; Lykes, 2013; Overstreet & Mathews, 2011; Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016). Similarly, their understanding of how poverty, housing insecurity, and limited resources frequently intersect systemic discrimination, oppression, and stigmatization to negatively impact resilience was also consistent with theory and research on intersectionality (Balfour, 2012; Crenshaw, 1989; Esmonde, 2002; Gustafson, 2009), and the association between ethnic minority
status and exposure to trauma or adversity as a result of sociocultural context, systemic barriers, and social or institutional oppression (Kwon, 2013, and Meyer, 2015, as cited in Alessi, 2016; Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Goel, Amatya, Jones, & Ollendick, 2014; Goodman, 2015; Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016). Given the professionals interviewed for this study frequently worked with survivors and individuals at-risk facing homelessness and housing insecurity due to a regional shortage of safe, affordable housing, they also emphasized the psychological impact of place and sense of home on resilience via their influence on sense of self, identity, belonging, and safety, security, and stability in addition to the practical implications of homelessness (Cox & Perry, 2011). Overall, participants concluded that resilience among survivors of trauma or adversity and individuals at-risk is fostered by social-ecological environments rich in relational and material resources that foster connectedness to others, provide accessible, consistent, and high-quality community and social support, and address basic needs in a manner that fosters a sense of safety, security, and stability.

Participants’ observations of the association between community and social support and resilience and the potential for community and social support to reduce or mediate trauma-related distress is consistent with recent research on resilience referenced throughout the systematic literature review, as well as seminal literature on resilience (Garmezy, 1987, 1991; Rutter, 1987, 1999, 2006, 2012, 2013; Werner 1995, 1996; Werner & Johnson, 2004). More specifically, participants underscored the importance of relatable support, peer-to-peer support, and support from those with shared experiences, as well as sociocultural or community engagement and recreation. However, they also cautioned that many forms of community and
social support are often less accessible to vulnerable minority or marginalized populations as a result of stigma or systemic oppression and discrimination, aligning with research demonstrating that such support is often disproportionately limited among minority populations (Alessi, 2016; Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016). Despite the nuanced nature of support and relational and material interpersonal resources afforded by families, friends, peers, professionals, and the community at large, participants emphasized the importance of a complimentary network of support in fostering resilience and the safety, security, and stability of interpersonal relationships and resources following trauma or adversity.

Perhaps most consistent with prior research on resilience was participants’ articulation of the link between resilience and social competence. Although participants noted that trauma-related mental health distress, developmental stage-related impacts of childhood exposure, and socially unfavourable coping mechanisms may impair the social competence of survivors or individuals at-risk, they also recognized the negative impact of poor parental or familial competence and/or childhood exposure to trauma or adversity on the social competence of survivors or individuals at-risk, in keeping with research illustrating the relationship between parental or familial competence and resilience and social competence among children at-risk (Garmezy, 1987, 1991; Felitti, et al., 1998; MacMillan & Violato, 2008; Miller-Graff, Howell, Martinez-Toreya, & Grein, 2016; Werner, 1995, 1996; Werner & Johnson, 2004). In turn, participants described how competent parents and caregivers serve as role models to demonstrate prosocial and adaptive coping behaviour, where relationships with parents and caregivers establish attachment styles, boundaries, expectations, and relational dynamics that permeate
other interpersonal relationships. Despite MacMillan and Violato’s (2008) conclusion that nurturing parenting and external social support function as resource factors that positively impact normative childhood development regardless of exposure to trauma or adversity (Luthar, Cicchetti, & Becker, 2000, Masten & Reed, 2002, and Werner & Smith, 1992, as cited in MacMillan & Violato, 2008), participants typically regarded competent and nurturing parents, caregivers, and/or adult roles models as assets or protective factors that support resilience. Overall, participants’ understanding of the role of early childhood experiences, parental and familial competence, and external social support was largely in keeping with findings illustrating their protective buffering effects following exposure to trauma or adversity in both seminal research (Garmezy, 1987, 1991; Rutter, 1987, 2006, 2012, 2013; Werner, 1995, 1996; Werner & Johnson, 2004), and more recent research on resilience (Feldman & Vengrober, 2011; Hines, 2015; Miller-Graff, Howell, Martinez-Toreya, & Grein, 2016).

Participants’ observations of impaired social competence among survivors and individuals at-risk likely reflect the direct and indirect effects of community and social support on resilience, aligning with a social-ecological model of resilience whereby relational variables directly and indirectly impact wellbeing (Feldman & Vengrober, 2011; Miller-Graff, Howell, Martinez-Toreya, & Grein, 2016; Ungar, Ghazinour, & Richter, 2013). Thus, the social competence and resilience of survivors and individuals at-risk is at least partially a product of socialization, as well as in direct response to the social competence of external social actors, creating reciprocal feedback loops that shape perceptions of the social-ecological environment, expectations, and behaviours in interpersonal relationships. Participants noted that the inability to
access or acquire adequate support despite support-seeking behaviour is especially troublesome for survivors and individuals at-risk, and contributes to feelings of hopelessness, powerlessness, and learned helplessness.

Notably, participants’ understandings of the impact of support-seeking behaviour and the receipt of social support on resilience aligned with Smith and colleagues’ (2015) variation of the enabling hypothesis of coping, where support-seeking reduces distress in the presence in higher levels of PTS among survivors of collective trauma by increasing perceived social support, which subsequently increases sense of self-efficacy and reduces trauma-related mental health distress. Therefore, not only does the social competence of external actors influence the social competence of survivors and individuals at-risk—it also influences their self-efficacy in a manner that encourages prosocial behaviour and future support-seeking by providing social models and positive reinforcement for adaptive social and coping behaviours that ultimately contribute to resilience. Consequently, participants advocated for psychoeducational strategies to reduce stigma and enhance mental health literacy and social competence among external social actors as a means to improve the quality of community and social support available to survivors of trauma and individuals at-risk. Moreover, participants recognized the need to enhance the social competence of external social actors as a means to improve available community and social support as being equally as important as enhancing trauma-informed community and social services, in keeping with their understanding of the need for complimentary networks of support and the diverse array of relational and material interpersonal resources afforded by supportive relationships with family, friends, peers, and professionals.
Conceptualizing Trauma-Informed Strengths-Based Approaches

Given consistency between participants’ conceptualizations of resilience and the role of community and social support with both seminal and more recent research in this area, participants’ service and approach considerations were largely congruent with the conclusions and recommendations stemming this body of work. Overall, participants ultimately agreed with the recurring theme that community-based initiatives should continue to focus on trauma-informed approaches and interventions that enhance community and social support networks (Hines, 2015; Lykes, 2013; Overstreet & Mathews, 2011; Somasundaram & Sivayokan, 2013), since enhancing the availability, accessibility, and quality of community and social support is likely the most viable approach to fostering resilience among survivors and individuals at-risk, especially when compared to more stable individual or contextual factors less amenable to change (Bonnano, Romero, & Klein, 2015; Goodman, 2015; Greenfield & Marks, 2010; Hobfoll, et al., 2009; Hobfoll, Stevens, & Zalta, 2015; Miller-Graff, Howell, Martinez-Toreya, & Grein, 2016; Miron, Orcutt, & Kumpula, 2014; Overstreet & Mathews, 2011; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012; Ungar, Ghazinour, & Richter, 2013). Within participants’ service design considerations, they described the need for a continuum of care characterized by a range complimentary trauma-informed multidisciplinary services including practical, advocacy and criminal justice supports, mental health supports and crisis intervention, and gender-specific and peer-to-peer supports, with special emphasis on client-centred care strategies, care continuity, and critical windows for intervention. The continuum of care envisioned by participants loosely resembled Overstreet and Mathews’ (2011) public health framework for
trauma-informed mental health services and mirrored Werner and Johnson’s (2004) conclusion regarding the need to generate a continuum of care that crosses disciplinary boundaries.

Additionally, participants’ focus on the primacy of basic needs aligned with the recommendation from prior research that practitioners must also attend to the practical challenges faced by survivors and individuals at-risk by providing social support, linkages to community organizations to meet basic needs, and assisting with relevant legal processes or proceedings beyond simply addressing the psychological implications of trauma or adversity (Burnett & Peel, 2001, Epstein & Carrillo, 2014, and Shuman & Bohmer, 2014, as cited in Alessi, 2016). For instance, participants described participating in activities of daily living with survivors and individuals at-risk, such as attending medical appointments, grocery shopping and attending food banks, making phone calls, scheduling, budgeting, and running errands. Not only did engaging in these activities with clients afford skill-building opportunities—it also enabled participants to engage in informal ‘street counselling’ outside of a traditional clinical setting, where this informal context may be preferred among individuals who are unwilling or unable to engage in formal interventions. Many participants understood their focus on basic needs as being related to the need to establish a sense of safety, security, and stability following trauma or adversity, with some also attributing it to marginalization faced by the demographics of clients they work with. Additionally, participants frequently described the benefit of peer-to-peer support among survivors and individuals at-risk, specifically when this support is gender-specific or from those with shared experiences, resembling Smith and colleagues (2015) confirmation of
the enabling hypothesis of coping and the positive influence of relatable, maximally-applicable social support from fellow survivors of collective trauma.

Beyond their service considerations, participants elaborated on multiple considerations for trauma-informed strengths-based approaches. Within a strengths-based approach, participants described the importance of recognizing existing resilience and intuitive understandings; professional competencies and strengths-based language; rapport-building and lived experience; first-time disclosures and self-identification; hope, perspective, and sense of self or identity; sense of self-efficacy, agency, and control; and establishing sense of safety, security, and stability. Although formal assessments to measure resilience or quantify protective factors were uncommon in their clinical practice, participants described using informal assessments, observations, and intuition to identify resilience and understand its highly-variable manifestations among unique individuals and across diverse contexts. However, the absence of formal assessments for resilience in clinical practice is not necessarily problematic, given resilience is not a singular quality or trait, and trait-based interview or questionnaire measures of resilience likely cannot adequately assess the full range of risk and protective factors (Rutter, 2006).

Notably, more recent literature examined within the systematic review did not recommend specific assessment tools for resilience in clinical practice, and instead encouraged practitioners to facilitate self-identification of personal histories of trauma or adversity, strengths, and sources of resilience and support among survivors and individuals at-risk (Agani, Landau, & Agani, 2010; Landau, 2010; Landau, Mittal, & Wieling, 2008). This approach, in conjunction
with the absence of formal assessments for resilience in clinical practice, may explain participants’ heavy reliance on intuitive understandings and recognizing existing resilience among survivors and individuals at-risk. Moreover, informal assessments, observations, and professional intuition may be better suited for assessing resilience as a three-part construct given the degree of individual- and contextual- variability in the development and manifestation of resilience as well as the overlap between trait-, outcome-, and process-based components of resilience that cannot be fully disentangled. Although participants did not provide explicit recommendations for the use of resilience assessments in clinical practice, recent literature on resilience has recommended that clinical assessments for intervention development and implementation incorporate evaluation methods that account for social-ecological determinants of resilience and the connectedness between individuals, families, and community, as well as the self-identified needs and goals of intervention participants (Agani, Landau, & Agani, 2010; Landau, 2010; Landau, Mittal, & Wieling, 2008).

When describing the importance of hope, perspective, and sense of self or identity, as well as sense of self-efficacy, agency, and control, participants typically focused on sense of agency and control as opposed to the predominant focus on self-esteem and self-efficacy within research on resilience, although these concepts are frequently discussed in conjunction with one another (Banyard & Williams, 2007; Bonanno, Brewin, Kaniasty, & La Greca, 2010; Bonnano, Romero, & Klein, 2015; Rutter, 1987; Ungar, Ghazinour, & Richter, 2013; Werner, 1995, 1996; Werner & Johnson, 2004). While a minority of participants explicitly referred to the need to foster self-esteem, a much larger proportion described the need to foster a sense of agency and
control through the self-identification of needs, strengths, and existing resources. In turn, the process of self-identification facilitates the self-determination of realistic plans and goals that enable survivors and individuals at-risk to engage in behaviours or activities that are individually-tailored and practically and personally rewarding in a manner that reinforces sense of self-efficacy, prosocial and adaptive behaviour, and resilience. Participants also identified various professional competencies imperative to trauma-informed strengths-based approaches, linking many of them to the importance of strengths-based language, rapport-building and lived experience, sensitivity within first-time disclosures, and facilitating self-identification and self-determination among survivors and individuals at-risk. By combining these strategies within strengths-based approaches, participants recognized survivors and individuals at-risk as experts in their own lives while establishing high-quality therapeutic relationships capable that afford support that compliments their inherent resilience and survivorship.

The largest inconsistencies within participants’ approach considerations pertain to specific professional competencies, the prevention and management of burnout, the promotion of professional resilience, and subsequent implications for trauma-informed community and social services. Professional competencies such as empathy, compassion, and awareness were not thoroughly discussed within the literature reviewed, nor were burnout or compassion fatigue, possibly as a result of the explicit focus on resilience and community and social support. Therefore, the limited attention to professional competencies and resilience, empathy, burnout, compassion fatigue, and implications for community and social services highlights a potential opportunity for future research.
Limitations

This study is subject to a number of methodological limitations, many of which stem from the constraints posed by a graduate-level thesis research study. A descriptive qualitative methodology was selected given its propensity to explore, describe, and explain the phenomenon under study (Kalof, Dan, & Dietz, 2008) in order to elucidate conceptualizations of resilience and the role of community and social support among a purposive sample of front-line community and social service professionals. However, as is often the case with descriptive qualitative research (Bickman & Rog, 2009), this study is insufficient to establish causal relationships between community and social support and resilience.

Although the systematic review of more recent research on resilience and community and social support within this thesis was based on the guidelines for Cochrane systematic reviews (Hannes, 2011) and a Rapid Evidence Quality Assessment Tool (Butler, Hodgkinson, Holmes, & Marshall, 2004, July, p. 48) for the critical appraisal of findings from qualitative and quantitative research, it is likely subject to limitations stemming from publication and exclusion bias (Butler, Hodgkinson, Holmes, & Marshall, 2004, July). First, this study is subject to publication bias as a result of the publication span specified within the systematic review of recent research, where the ten-year publication span was imposed due to the breadth of resulted retrieved through the database searches. Second, this study is subject to exclusion bias as a result of the exclusion of grey literature, approaches, and interventions without methodologically robust evaluations, and related concepts such as post-traumatic growth, dispositional optimism, and psychological hardiness. The exclusion of grey literature was due to the absence of an empirical assessment
tool to evaluate such literature with an acceptable degree of rigour, and the exclusion of related concepts was due to variable theoretical origins and conceptual or operational distinctions (Bonnano, Romero, & Klein, 2015; Goodman, 2015; Ungar, Ghazinour, & Richter, 2013). Thus, further examination of grey literature and the relationship between resilience and related concepts would likely be worthy areas of focus within future research.

Community and social service professionals were recruited for this study using a non-probabilistic purposive snowball sample of the principal investigator’s network of professional contacts and colleagues wherein data collection, transcription, coding, and analysis were conducted solely by the principal investigator. Although independent coding and analysis afforded greater consistency in the research process, it failed to provide opportunities to assess inter-coder reliability or for participants to confirm key themes (Fereday & Muir-Cochrane, 2006), where involvement of multiple coders or analysts and use of a participant focus group could have further reduced bias in this study. Additionally, despite the relatively small sample size for this study, Guest, Bunce, and Johnson (2006) demonstrated data saturation and code stability within twelve in-depth interviews, and concluded that six to twelve interviews are sufficient to achieve data saturation within purposive homogenous samples with high-quality research instruments, data, and a clearly-defined domain of inquiry. Although the educational backgrounds and professions of participants were somewhat heterogeneous, their broader knowledge of and familiarity with the research topic within the context of community and social services was relatively homogenous. Moreover, this marginal degree of heterogeneity may
actually strengthen findings from this study in light of the consistency of themes across the data set, as well as with prior research.

Triangulation of data across the sample and systematic review of literature enhanced the reliability and validity of current findings and reduced potential bias by enabling: i) assessment of interview data accuracy and quality; and, ii) integration and comparison of data from multiple participants and prior theories, concepts, and findings (Bickman & Rog, 2009; Kalof, Dan, & Dietz, 2008; Fetterman, 2009; Maxwell, 2009). However, data from the current study lacks sufficient external validity to apply generalizations or conclusions to other populations or contexts (Bickman & Rog, 2009; Maxwell, 2009), and cannot be assumed to be representative among other population groups or professionals in other geographic settings or timeframes. Generalizability in this study could have been enhanced with a larger, more representative sample size, yet generalizability in qualitative research is typically based on analytical–rather than statistical–generalization, or transferability via the development of a theory applicable beyond the research setting (Beck, 1991, Guba & Lincoln, 1989, Ragin, 1987, and Yin, 1994, as cited in Maxwell, 2009). Likewise, transferability and generalizability in qualitative research with non-probabilistic samples can be enhanced through corroboration with other studies (Hammersley, 1992, and Weiss, 1994, as cited in Maxwell, 2009). Although triangulation and corroboration with other studies do not permit the extrapolation of representative conclusions associated with probabilistic samples and quantitative methodologies (Maxwell, 2009), triangulation of in-depth interview data with theories, concepts, and findings from prior research further bolsters the transferability of findings and credibility of generalizations from this study.
Despite aforementioned limitations, this study provides additional insight on professional intuitions, observations, practices, and expertise as an applied knowledge-base for fostering resilience through a compelling and experientially-credible account of participants’ conceptualizations of trauma, adversity, resilience, and the role of community and social support among survivors of trauma or adversity and individuals at-risk. The cross-sectional snapshot provided in this study enhances a professional understanding of trauma-informed strengths-based resilience-building approaches and interventions with survivors of trauma or adversity and individuals at-risk, wherein the conclusions and recommendations stemming from these findings are directly relevant to the emergent needs and local context of available community and social services in the region. The final chapter of this study presents these conclusions and recommendations.
Chapter 6 – Conclusions & Recommendations

Conclusions

Five key themes were identified through a hybridized thematic analysis of in-depth interviews with a purposive sample of ten community and social service professionals. The first and second themes articulating resilience as a three-part construct and secondary conceptual considerations for resilience, respectively, address the first research question regarding professional conceptualizations of resilience. Likewise, the third and fourth themes describing the continuum of risk and protection and community and social support address the second research question regarding professional conceptualizations of the role of community and social support in fostering resilience. Finally, the fifth theme encompassing service and approach considerations addresses the third and final research question regarding how community and social services can foster resilience among survivors of trauma or adversity and individuals at-risk.

The ten community and social service professionals interviewed for this study primarily conceptualized resilience as a three-part construct comprised of trait-, outcome-, and process-based components. Additionally, these professionals highlighted secondary conceptual considerations for resilience pertaining to definitions of trauma and adversity, dimensions of diversity, and distinction from and coexistence with distress and recovery. Overall, participants’ conceptualizations of resilience among survivors and individuals at-risk were congruent with key findings and themes from prior research on resilience, highlighting the dynamic and individualized nature of this phenomenon, wherein resilience is not synonymous with recovery, a
lack of trauma-related mental health distress, return to baseline functioning, avoidance of risk, or linear healing trajectories.

Participants’ conceptualizations of the role of community and social support in fostering resilience among survivors and individuals at-risk were grounded in a continuum of risk and protection characterized by the potential for duality and complex, cumulative, and individual-and context-specific interactions between risk and protective factors. Participants universally recognized the positive impact of community and social support, highlighting both the generalized positive effects of community and social support for all individuals alongside the direct protection afforded by such support in the presence of exposure to trauma or adversity. Likewise, they typically regarded social isolation and the absence or loss of community and social support as risk factors for unfavourable mental health outcomes following trauma or adversity, despite the potential for social isolation to exert protective effects via the avoidance of triggers, recurrent re-traumatization, stigma, and frequent negative social interactions.

The majority of participants understood the social-ecological environment as being more influential than individual characteristics on resilience given its impact on the availability, quantity, and quality of sources of community and social support, whereby resource-rich environments rich in accessible, consistent, and high-quality resources that foster connectedness to others and address basic needs in a manner that fosters a sense of safety, security, and stability are especially conducive to resilience. Thus, they conceptualized the role of community and social support in fostering resilience as contributing to a reservoir of relational and material interpersonal resources established by a complimentary network of support. By extension, the
quality of such support is further shaped by the social competency of external social actors, survivors, and individuals at-risk through feedback loops established within patterned social exchanges that provide opportunities for experiential social learning and modeling, whereby positive interactions promote self-efficacy, communal mastery, prosocial and adaptive coping behaviour, and resilience.

Based on their conceptualizations of resilience and the role of community and social support, participants described multiple related service and approach considerations for community and social services. Within their service design considerations, participants advocated for a continuum of care characterized by complimentary trauma-informed multidisciplinary services involving practical, advocacy, and criminal justice supports; mental health supports and crisis intervention; gender-specific and peer-to-peer supports; and client-centred care strategies and care continuity. Additionally, they highlighted the importance of critical windows for intervention and the need for additional funding and resources for trauma-informed community and social services, reiterating that inaccessible, inefficient, and/or ineffective programs and services discourage support-seeking behaviour, disrupt opportunities for positive change, and translate to the lack or loss of resources for survivors and individuals at-risk.

Within participants’ strengths-based approach considerations, they emphasized their reliance on intuitive understandings and the recognition of existing resilience. Additionally, participants highlighted various professional competencies related to professional awareness and empathy; strengths-based language; rapport-building and lived experience; sensitivity within
first-time disclosures; and facilitating self-identification and self-determination. Participants frequently sought to foster hope, perspective, and sense of self or identity among survivors and individuals at-risk, and often incorporated arts-based, self-expressive, mindfulness, and group activities within their clinical practice. More specifically, participants frequently encouraged the self-identification of histories of trauma or adversity, needs, strengths, and resilience among survivors or individuals at-risk, and sought to facilitate the self-determination of realistic plans and goals that leverage existing resources and assets in a manner that fosters a sense of self-efficacy, agency, and control. However, they also underscored the importance of establishing sense of safety, security, and stability in order to foster a sense of agency and control among survivors and individuals at-risk, where this may be especially difficult in the presence of recurrent re-traumatization, triggers, marginalization, and/or intersectionality (Balfour, 2012; Crenshaw, 1989; Esmonde, 2002; Gustafson, 2009). Overall, participants understood trauma-informed strengths-based approaches as a means to enable survivors and individuals at-risk to self-identify needs, strengths, goals, identity, and experiences while leveraging existing assets and resources, thereby acknowledging individuals as experts in their own lives while establishing high-quality therapeutic relationships with competent trauma-informed professionals capable of extending support that compliments their inherent resilience and survivorship.

Finally, participants highlighted considerations for the prevention and management of professional burnout and the promotion of professional resilience. Despite the rewarding nature of their work, participants described burnout and compassion fatigue as exceedingly prevalent. Beyond burnout related to high caseloads, inadequate employment resources, or overburdened
programs or services, the nature of clinical practice with survivors of trauma or adversity and individuals at-risk often results in vicarious trauma reactions among professionals, especially if they too are survivors of trauma or adversity. Participants emphasized that not only does burnout negatively impact their own health and wellbeing— it also negatively impacts professional competence in a manner that compromises the care provided to survivors and individuals at-risk. In turn, they emphasized the importance of caring for caregivers in a manner that promotes professional resilience and maintains professional empathy while preventing burnout and compassion fatigue despite the demands associated with community and social service work.

**Implications & Recommendations**

A number of implications and recommendations to enhance community and social services in a manner that enables them to foster resilience among survivors of trauma or adversity and individuals at-risk can be extracted from this study. Based on the themes identified within the data generated through in-depth interviews with a purposive snowball sample of ten community and social service professionals, three broad categories of recommendations regarding: i) the conceptualization of resilience; ii) the role of community and social support; and iii) the incorporation of trauma-informed resilience-building strengths-based approaches have been identified. The following recommendations pertain to clinical and practical conceptualizations of resilience among survivors and individuals at-risk within community and social services:
It is recommended that practical conceptualizations of resilience...

1. **Be grounded by definitions of trauma and adversity** that recognize the under-reported prevalence of such experiences and account for the snowball effect of cumulative trauma or adversity across the life course. Definitions of trauma and adversity must acknowledge the full range of subjective human experiences; extend beyond the diagnosis of PTSD to encompass gender-specific trauma, C-PTSD, and ACEs; and avoid the militarization or romanticization of trauma and PTSD.

2. **Recognize resilience as a three-part construct**, that: i) involves multiple traits that develop over time alongside universal and innate capacities for resilience; ii) reflects a relatively prevalent outcome that can manifest as a silver-lining following trauma or adversity; and most importantly, iii) is most accurately understood as a dynamic, nonlinear, and ongoing process that evolves through phases and stages across the life course.

3. **Account for dimensions of diversity through a contextualized intersectional perspective of resilience**. Dimensions of diversity influence the evolution and manifestation of resilience through their impact on individuals’ subjective experience of their social-ecological environments and trait-, outcome-, and process-based components of resilience.

4. **Account for resilience as a component of ongoing recovery that frequently coexists with distress within nonlinear trajectories**. The absence of trauma-related mental health distress and return to baseline functioning is not synonymous with resilience; a
return to baseline functioning may not be possible or desirable, and expectations for ‘full’
or ‘complete’ recovery are unrealistic.

Similarly, the following implications are drawn from participants’ conceptualizations of the role
of community and social support in fostering resilience among survivors of trauma or adversity
and individuals at-risk:

*It is recommended that the role of community and social support be recognized as...*

1. **Existing within a continuum of risk and protection.** This continuum is characterized
   by the dual potential for concurrent and highly variable risk and protective mechanisms,
   where the avoidance of risk is not synonymous with resilience, and the ultimate risk or
   protection afforded by any given factor is largely dependent on the cumulative interaction
   of individual- and context-specific variables.

2. **Exerting a positive influence on wellbeing for all individuals, and protective effects
   in the presence of exposure to trauma or adversity that contribute to resilience and
   reduce trauma-related mental health distress.** Conversely, social isolation and the loss
   of community and social support are best understood as risk factors, barring the
   protective effects of social isolation in the presence of stigma, recurrent re-traumatization
   or triggers, and/or exposure to frequent negative social interactions.

3. **Contributing to a resource-rich environment shaped by broader social-ecological
   influences.** The social-ecological environment exerts a disproportionate influence on
   resilience compared to individual characteristics or person-centred variables. Resource-
   rich environments are those rich in resources that foster connectedness to others, provide
accessible, consistent, and high-quality community and social support, and address basic needs in a manner that fosters a sense of safety, security, and stability.

4. **Contributing to a reservoir of relational and material interpersonal resources established by complimentary networks of support.** Families, friends, peers, professionals, and community each afford unique relational and material resources that fulfill the fundamental human need for connectedness to others, reduce trauma-related mental health distress, and contribute to a sense of safety and stability within interpersonal relationships that enables survivors and individuals at-risk to form healthy, meaningful connections with others. Relatable support, peer-to-peer support, and support from those with shared experiences are especially valuable in fostering resilience. Conversely, the lack or loss of community or social support constitutes the absence or erosion of interpersonal resources.

5. **Being influenced by the social competencies of external social actors, survivors, and individuals at-risk via reciprocal feedback loops established through patterned social interactions.** Although exposure to trauma or adversity may negatively impact social competence among survivors and individuals at-risk, the social competence of external actors—especially parents, caregivers, and family members—further shapes relational dynamics and social exchanges. Social interactions that are distressing, triggering, or re-traumatizing promote social isolation through negative reinforcement of prosocial support-seeking behaviour and the modeling of problematic patterned social exchanges, thereby contributing to a sense of hopelessness and helplessness. Conversely, positive interactions with socially competent actors that result in the receipt of support
and the development of healthy, meaningful interpersonal relationships promote self-efficacy, communal mastery, prosocial and adaptive coping behaviour, and resilience through positive reinforcement and the provision of social learning and modeling opportunities.

Finally, the following recommendations stem directly from the service and approach considerations highlighted by this sample of community and social service professionals:

*It is recommended that community and social services aiming to foster resilience among survivors of trauma or adversity and individuals at-risk...*

1. **Include psychoeducational strategies to enhance social competence.** Such strategies include the promotion of mental health literacy, mental health first aid, and the reduction of stigma surrounding trauma, adversity, mental health, poverty, and substance use and chemical dependency, and are intended to improve the quantity and quality of community and social support naturally available to survivors and individuals at-risk within the social-ecological environment.

2. **Establish a continuum of care.** This continuum of care should capitalize on critical windows for intervention, prioritize client-centred care strategies and care continuity, and include complimentary trauma-informed multidisciplinary services such as: practical, advocacy, and criminal justice supports; mental health supports and crisis intervention; and gender-specific and peer-to-peer supports.

3. **Leverage intuitive understandings of resilience and facilitate recognition of existing resilience among survivors and individuals at-risk.** Recognition of existing resilience
requires careful attention to: trait-, outcome-, and process-based components of resilience; dimensions of diversity; the duality of risk and protective factors; and the disproportionate influence of the social-ecological environment versus individual characteristics or person-centred variables on resilience.

4. **Be facilitated by competent, trauma-informed professionals cognizant of how their beliefs, values, and assumptions are translated within their clinical practice.**

Professional awareness and empathy, strengths-based language, rapport-building strategies that leverage lived experience, and sensitivity within first-time disclosures of histories of trauma or adversity are key to trauma-informed strengths-based practice.

5. **Encourage the self-identification of experiences, identity, needs, strengths, and goals among survivors and individuals at-risk.** This process of self-identification enables professionals and survivors or individuals at-risk–as collaborating clinical and experiential experts–to facilitate the self-determination of realistic plans and goals in a manner that fosters a sense of self-efficacy, agency, and control, as well as hope and perspective.

6. **Establish a sense of safety, security, and stability among survivors and individuals at-risk.** A sense of safety, security, and stability enables survivors and individuals at-risk to address basic needs and trauma-related mental health distress; form healthy, meaningful interpersonal relationships; and engage in trauma-informed community and social services. Establishing a sense of safety, security, and stability is closely intertwined with fostering a sense of agency and control.
7. **Support professional wellbeing, competency, and meaningful long-term engagement in clinical practice.** Supporting community and social service professionals involves caring for caregivers through wellness strategies focused on: the prevention and management of professional burnout and/or compassion fatigue; the promotion of professional resilience; and the balancing of cognitive and emotional empathy.

In light of findings from this study, additional research is warranted to test these recommendations, assess the efficacy of trauma-informed strengths-based approaches within community and social services, and evaluate the impact of burnout and empathy on professional competence and resilience among community and social service professionals. Despite methodological limitations and the need for additional research, this study leverages front-line professionals’ knowledge, expertise, and lived experience in their work with survivors of trauma or adversity and individuals at-risk alongside research on resilience and community and social support. By combining the expertise and lived experience of front-line professionals with recent theoretical and empirical knowledge on resilience and community and social support, findings from this study can enhance practical understanding and application of these concepts within the context of community and social services, with accompanying recommendations to foster resilience among survivors of trauma or adversity and individuals at-risk.
References


doi:10.4135/9781483348858


doi:10.1177/1529100610387086


doi:10.1080/1047840X.2015.992677


Garmezy, N. (1987). Stress, competence, and development: Continuities in the studies of schizophrenic adults, children vulnerable to psychopathology, and the search for stress-
doi:http://dx.doi.org/10.1111/j.1939-0025.1987.tb03526.x

doi:https://doi.org/10.1177/0002764291034004003


doi:10.1177/1525822X05279903


drawings. *Traumatology*, 23(1, Special issue: Resilience and trauma: Expanding definitions, uses, and contexts), 68-81. doi:http://dx.doi.org/10.1037/trm0000090


doi:http://dx.doi.org/10.1080/10615806.2014.969719


doi:http://dx.doi.org/10.1186/1752-4458-7-3


doi:http://dx.doi.org/10.3402/ejpt.v5.25338


doi:10.1037/a0024929


Appendix A – Informed Consent Form

INFORMED CONSENT FORM

Front-line Perspectives: Conceptualizations of trauma, adversity, resilience, and community and social support

Eligibility Criteria:

- 18 years old or older.
- Fluent in English and able to personally give informed consent to participate in the research.
- Professional experience working in community and social services (including public and non-profit organizations) that deliver services to survivors of trauma or adversity and individuals at-risk. This includes professions such as: probation and/or parole officers, mental health and/or crisis workers, social workers, counsellors, therapists, psychologists and/or psychiatrists, and other relevant community and social service professionals.

Please do not hesitate to ask about your eligibility!

Dear Potential Participant,

You are invited to participate in my Royal Roads University research study called FRONT-LINE PERSPECTIVES: CONCEPTUALIZATIONS OF TRAUMA, ADVERSITY, RESILIENCE, AND COMMUNITY AND SOCIAL SUPPORT*

This research opportunity seeks to improve the mental health and psychosocial supports provided by front-line workers in community and social services. I seek to understand what you think it means to be resilient following trauma or adversity. This study specifically looks at how community and social service professionals understand resilience, what types of things they think can help make someone more resilient, how community and social support can influence resilience, and what community and social services can do to foster resilience following trauma or adversity–based on the expertise of front-line professionals. The purpose of this research project is two-fold: i) to explore the compatibility of existing theoretical knowledge about resilience with community and social service professionals’ practical understanding and application of resilience and the role of community and social support; and, ii) to explore the role of community and social services in fostering resilience among survivors of trauma or adversity and individuals at-risk.

If you are interested in participating in this research, please review the following items and complete and return the consent form to the principal investigator.

1. Participation Scope. By participating in this research, it is requested that you participate in a face-to-face interview on the research topic. The interview questions are non-invasive, and will focus on professional knowledge and experiences related to supporting survivors of trauma or at-risk individuals; this could include any patterns or trends noticed, what factors you believe influence resilience or other positive or negative outcomes following trauma or
adversity, or your understanding of the role of community and social support in fostering resilience. This interview will require a maximum of two hours of your time. Participants

*This study was approved by the Royal Roads University Research Ethics Board on June 28th, 2017.

will also have the optional opportunity to review and approve the transcribed interview before it is used in the research (discussed below); this should only take an additional two hours of your time. The face-to-face interviews for this research are projected to take place between September, 2018 and January, 2019.

I have read and understood the contents of this section. Participant initials: _______________

2. **Location & Audio-recording.** The face-to-face interview can take place in a location of the participant’s choice; this could include a place of residence or employment, or a quiet public location. Participants are encouraged to select a location in which they would feel comfortable discussing this topic with the principal investigator. The face-to-face interview will be audio-recorded using a hand-held audio-recording device; by consenting to participate in the interview, you are also consenting to the audio-recording of this interview. Immediately following the interview, the audio-recording of the will be transferred to a private, designated USB key only accessible to the principal investigator, until it is used to manually transcribe the conversation and then permanently destroyed to protect participants’ confidentiality, privacy, and anonymity. Audio-recordings will be destroyed after interviews are completed and transcribed. Participants have the optional opportunity to be notified by the principal investigator when the audio-recording of the interview is destroyed; please specify your preference regarding this notification in the space provided in the informed consent form.

I have read and understood the contents of this section. Participant initials: _______________

3. **Transcripts.** Prior to the destruction of the audio-recording of each interview, this recording will be used to facilitate the manual transcription of the interview. This original transcript of the interview will then be anonymized, where all potentially identifying information such as names, dates, specific places of employment, and information obtainable in public or private records will be removed prior to the analysis. Original transcripts are projected to be destroyed during the months of September, 2018 through January, 2019, preserving only anonymized interview transcripts. As mentioned in item no. one (Participation Scope), participants have the optional opportunity to review and approve the anonymized interview transcript prior to its inclusion in the analysis; this would take approximately two hours of your time. Please specify your preference regarding this review in the space provided in the informed consent form.

I have read and understood the contents of this section. Participant initials: _______________

4. **Confidentiality, Privacy, & Anonymity.** Although the principal investigator will know the identities of participants during the face-to-face interviews, any information disclosed to the
principal investigator at any point in time will remain absolutely private and confidential – anything said, and any information disclosed for the purpose of this research will only be used specifically for this research, and will not be used or retained for any other purpose. By promptly destroying the audio-recordings used to create each interview transcript, it will not be possible to re-identify participants through their voice and/or mannerisms. By removing all potentially identifying information from the interview transcripts and assigning them a random numeric code and pseudonym after each participant has accepted or declined the opportunity to review and approve their transcripts, it will not be possible to re-identify participants based on content within their interviews. However, participants are afforded the opportunity to select their own pseudonym to be used within the final research publication at the end of this informed consent form. By doing so, the principal investigator will be able to re-identify any participants who have selected their own pseudonym, but shall never disclose any participants’ identities, involvement, and/or use of a pseudonym within this research. No record linking participant identities, informed consent forms, or the random numeric codes assigned to each interview will be developed or retained at any point in time unless explicitly limited to participants’ selection of their own pseudonym within this form. All of these measures have been taken to reduce the risk of accidental re-identification by the principal investigator and/or intentional re-identification by a third party. Participants’ identities, and/or any information that could specifically link participants to this research or be used to identify them will not be included in the analysis or final publication. Participants’ generic profession/job title and professional background and experiences will be documented, but participants’ specific places of employment or any other affiliations will not be disclosed at any point in time.

I have read and understood the contents of this section. Participant initials: ______________

5. Participation & Withdrawal. All participation in this research is voluntary. As a potential participant, you have the right to decline this invitation to participate in the research and shall face absolutely no penalty or consequence for doing so. You also have the right to stop the interview procedure, ask questions, and/or change your mind in respect to answering a question, or choose not to participate and/or withdraw at any point during the interview process (e.g., after providing consent; prior, during, or following the interview; during your transcript review) without penalty or consequence. It is solely your choice to participate, to stop the interview at any point, or to request that your information not be used in the research. Any decision to participate and/or withdraw from the research will not have any impact on standing within the community, with one’s employer, and/or any other personal or professional affiliations. In the event a participant chooses to withdraw from the research, any information collected for the purpose of this research, including consent forms, audio-recordings, original transcripts, and anonymized transcripts will immediately be destroyed. The window of opportunity to withdraw from the research is determined by your preferences in this informed consent form, as per the following options:

- If a participant chooses to not be notified by the principal investigator when the audio-recording of their interview is destroyed, and to not review and approve their anonymized
interview transcript, their final opportunity to withdraw from the research will be at the end of their face-to-face interview.

- If a participant chooses to be notified by the principal investigator when the audio-recording of their interview is destroyed, but to not review and approve their anonymized interview transcript, their final opportunity to withdraw from the research will be when they are notified their audio-recording has been destroyed. Following the destruction of the audio-recording, interview transcripts will be anonymized and assigned a random numeric code for analysis, and will no longer be able to be withdrawn from the research.

- If a participant chooses to not be notified by the principal investigator when the audio-recording of their interview is destroyed, but chooses to review and approve their anonymized interview transcript, their final opportunity to withdraw from the research will be when they review and/or approve their transcript. Following the anonymized transcript review, transcripts will be assigned a random numeric code for analysis, and will no longer be able to be withdrawn from the research.

I have read and understood the contents of this section. Participant initials: ______________

6. Storage & Retention. Informed consent forms will be stored separate from all participant data collected, and in a locked filing cabinet only accessible to the principal investigator. Audio-recordings of interviews, original transcripts, and anonymized transcripts will be stored offline on a private designated USB key only accessible to the principal investigator. When not in use, this USB key shall be stored in a locked filing cabinet only accessible to the principal investigator, and its contents shall only be accessed via a private password, firewall, and anti-virus software protected computer. Audio-recordings and original transcripts shall only be retained until audio-recordings are transcribed, the principal investigator prepares an anonymized transcript, and participants have accepted or declined the opportunity to review and approve their anonymized transcript, at which point they shall be permanently removed from the USB key (during September, 2018 through January, 2019). Only informed consent forms and anonymized interview transcripts will be retained following this procedure, whereby only anonymized interview transcripts will be used for analysis. Following revisions, external review, formal defense, approval, and publication projected to be completed by October, 2019, anonymized interview transcripts and informed consent forms will either be destroyed, or retained for only the specified length of time required by the Royal Roads University Research Ethics Board. No record linking participant identities within data, informed consent forms, and random numeric codes assigned to anonymized transcripts will be developed or retained at any time to reduce the risk of accidental re-identification by the principal investigator and/or intentional re-identification by a third party. In the event that electronic drafts of the research are shared with the Academic Supervisor nominated for this research via email or cloud-based (online) file-sharing platforms, only anonymized participant data will be included. Any cloud-based (online) file-sharing platforms used for this purpose will be password protected, formatted to restrict access to only those persons previously approved by the researcher (e.g., the Academic Supervisor), and immediately removed and/or destroyed following completion of the research.
7. Perceived, Implied, or Actual Conflicts of Interest. The principal investigator was nominated and elected as the Chair of the Board of Directors of the Elizabeth Fry Society of Simcoe County in June, 2018, and previously served as the Board Secretary from June, 2015 to June, 2017, and the Vice-Chair from June, 2017 to June, 2018. All of these positions are volunteer roles, and are not salaried positions. The principal investigator has also prepared reports and analyses of surveys of agency clients in a volunteer capacity. The principal investigator does not hold a position of power over any individuals previously or currently associated with this agency, as the Board of Directors is not mandated to oversee or exercise any authority over day-to-day organizational operations, including the recruitment, hiring, discipline, and/or dismissal of agency staff and/or volunteers, other than the employment contract and professional evaluation of the Executive Director via organizational performance. Moreover, the Board governs through a Policy Governance Model that is removed from day-to-day organizational operations and is solely focused on Board governance and oversight of the Executive Director via organizational performance, whereby the Board’s authority may only be exercised as a collective and in accordance with its policy manual. As the Chair of the Board and as a volunteer for this agency, the principal investigator’s interactions with staff, volunteers, and clients are rare and are not clinical or operational in nature. The principal investigator is not involved in any of the services or programs this agency provides to its clients, and has no decision-making authority in how these programs or services operate. Although the principal investigator does not possess any professional authority over volunteers and/or staff, the Board as a collective is responsible for its own membership, including recruitment, nominations, discipline, evaluation, policy development and governance, and succession planning. The principal investigator’s current role in this agency primarily involves leadership, general oversight, Board governance, and policy monitoring and development. As this research is not designed or intended to assess the agency, services provided, and/or individual performance, no information that reflects positively or negatively on a specific organization, individual, program, or service will be collected or included in the research. Participation in this research will not in any way lead to the collection and/or disclosure of any information that could have direct or indirect implications related to any individuals associated with this agency, or the agency itself. In a preamble to the final research publication, the principal investigator will disclose her affiliation with this agency, but this disclosure is solely included for the sake of transparency and is not reflective of an affiliation with this agency for the purpose of this research, nor is it reflective of the participation or involvement of any specific individuals. Participation in this research shall have no direct or indirect impact on any individual’s current or future standing with this agency, and any decision to participate, withdraw, or any other information collected for the purpose of this research shall never be disclosed to this agency or any other third party. Participants should disregard the principal investigator’s affiliation with this agency in their personal decision to participate, and as per item no. five (Participation & Withdrawal), face absolutely no consequences for their decision to participate, not participate, or to withdraw in accordance with the outlined procedures.
8. **Potential & Actual Risks.** The scope of this research and its procedures conform to the standards of minimal risk for research involving human participants as outlined by the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans, and has been approved by the Royal Roads Research Ethics Board. This research, including the accompanying procedures, analysis, findings, and dissemination will not expose participants to any potential direct risks or harms, will not ask invasive and/or unnecessarily personal or intrusive questions of participants, and will not evaluate individual or professional performance. Due to the potential for vicarious (or secondary) trauma and employment-related distress within various helping professions, the principal investigator shall not proceed with the interview procedure in the event that a participant displays or verbalizes any signs of distress as a result of any of the questions posed. In the event a participant experiences distress at any point during the interview procedure, the principal investigator shall provide the participant with a paper copy of local mental health and supportive services. By upholding the ethical obligations of confidentiality, privacy, and anonymity as per the measures outlined in item no. four (Confidentiality, Privacy, & Anonymity) the identities of all potential and actual participants will be protected and not distinguishable within the analysis or final research. As no record linking participant identities and informed consent forms to random numeric codes assigned to anonymized interview transcripts will be developed or retained at any time, the risk of accidental re-identification by the principal investigator and/or intentional re-identification by a third party is substantially decreased. All information collected for the purpose of this research shall be handled strictly in accordance with the procedures outlined in items no. five and six (Participation & Withdrawal and Storage & Retention). Therefore this research, the interview procedure, analysis, and/or any implications stemming from the findings and/or dissemination of this research would not pose any risk of physical and/or psychological injury, material and/or immaterial harm, or any other repercussions to any participants, organizations, and/or other third parties.

9. **Potential & Actual Benefits.** Participating in this research may be seen as beneficial by participants, as it provides a purposeful and rewarding opportunity to share professional expertise and/or experiences as community or social services professionals in a meaningful way. As participants may select their own pseudonym for use in the final research publication within this informed consent form, participants also have the opportunity to personally and/or publicly identify their individual contribution to the research. The choice to ever disclose their involvement and/or the use of a pseudonym in this research is solely at the discretion of individual participants. There are no direct rewards and/or benefits to participants as a result of participating in this research, although participants will be offered a twenty-five dollar (CAD) gift card as a token of thanks for their contributions to the research. The completed research project may assist those seeking to understand what it means to be resilient following trauma or adversity, the role of community and social support, and how community and social services can be mobilized to support those affected by trauma or
adversity. As this research is intended to enhance the understanding of resilience by analyzing existing constructs in conjunction with professional expertise, this research may be particularly valuable to various helping professionals, researchers, and/or academics studying resilience. This research may also potentially serve as a future organizational resource for developing programs, policies, or services by articulating linkages between the theoretical concept of resilience and its professional understanding, relevance, and utility. This research shall not result in an immediate or short-term, material, direct reward or benefit to the principal investigator aside from fulfilling a component of the Master of Arts in Interdisciplinary Studies program at Royal Roads University. It is also possible that the publication and dissemination of this research could directly and/or indirectly impact the principal investigator’s academic and/or professional standing.

I have read and understood the contents of this section.  
Participant initials: __________________

10. Publication & Dissemination. The findings from this research in the form of an executive summary will be shared with local community and social service agencies that provide support to survivors of trauma or adversity and individuals at-risk. This executive summary will include an invitation to request a copy of the full research publication at no cost, along with the principal investigator’s contact information. A copy of the final research publication will also be submitted to the Resilience Research Centre (Resilience Research Centre, n.d.). As this research is being conducted as a component of the Master of Arts in Interdisciplinary Studies program at Royal Roads University, the final research publication will be submitted to the university. Upon its review, this research shall be published and archived within the university’s library and will be available for future review and reference by students and faculty. Participants will be provided an executive summary and/or copy of the full research publication upon completion (projected for October, 2019), based on their preference specified in the informed consent form. Please specify your preference to receive a copy of this research upon completion in the space provided at the end of the informed consent form.

I have read and understood the contents of this section.  
Participant initials: __________________

11. Informed Consent. By completing the attached informed consent form and returning it to the principal investigator, you are indicating you have read and understood these terms in full, and are consenting to participate in the research in accordance with these terms. As a potential participant, you have the right to contact the principal investigator and/or academic supervisor for this research if you have any questions and/or concerns at any point in time. As a potential participant, you also have the right to decline this invitation to participate in the research and shall face absolutely no penalty or consequence for doing so. As a participant, you have the right to stop the interview procedure, ask questions, and/or choose not to participate at any point during the interview process (e.g., after providing consent; prior, during, or following the interview; during your transcript review) without penalty or consequence. All participation in this research is voluntary - it is solely your personal choice to participate, to stop the interview at any point, or to request that your information not be used in the research. If you choose to withdraw from the research as per item no. five
(Participant & Withdrawal), any information collected from you for the purpose of this research, including consent forms, audio-recordings, original transcripts, and anonymized transcripts will immediately be destroyed. Please be sure to review the timeline and procedures for withdrawal outlined in item no. five (Participation & Withdrawal). No record linking participant identities within data, informed consent forms, and anonymized transcripts will be developed or retained at any time to reduce the risk of accidental re-identification by the principal investigator and/or intentional re-identification by a third party. Informed consent forms will be stored separate from all participant data collected, and in a locked filing cabinet only accessible to the principal investigator. Only informed consent forms and anonymized interview transcripts will be retained, whereby only anonymized interview transcripts will be used for analysis. These items will be destroyed upon completion of the research (projected for October, 2019), or retained in a locked filing cabinet only accessible to the principal investigator for only the specified length of time required by the Royal Roads University Research Ethics Board.

I have read and understood the contents of this section. **Participant initials:**

It is asked that participants retain this document in its entirety for their records. If you have any questions about the research project or your role as a participant, please do not hesitate to inquire during the opportunity provided immediately prior to and following the interview procedure, or to contact the principal investigator or academic supervisor in advance. Thank you for your time and consideration. Please complete and return the consent form to the principal investigator if you are interested in participating in this research.

Sincerely,

Leah Catton, Principal Investigator
INFORMED CONSENT FORM
Front-line Perspectives: Conceptualizations of trauma, adversity, resilience, and community and social support

Please complete and initial the following sections, sign and date the final section of this form, and return a copy to the principal investigator. Please retain a copy of this form for your records. This form will only be accessed by the principal investigator and will be stored in a locked cabinet separate from all other research materials. In the event you wish to withdraw from the research, this form will immediately be destroyed along with all other information collected from you.

SECTION 1: AUDIO-RECORDING & TRANSCRIPT

Substantial measures have been taken to protect participants’ rights to confidentiality, privacy, anonymity, and integrity. These measures included the prompt destruction of the audio-recording of your interview after it has been transcribed and the anonymization of your interview transcript whereby all potentially identifying information shall be removed.

Please specify whether you would like to be notified by the principal investigator when the audio-recording of your interview is destroyed, and/or to review and approve your anonymized interview transcript.

___ Yes, I want to be notified by the principal investigator when the audio-recording of my interview is destroyed.
___ Yes, I want to review and approve my anonymized interview transcript before it is used in the research.

Name: _______________________________________
Phone: ______________________________________
Email: _______________________________________

NOTE: The window of opportunity to withdraw from the research is determined by your preferences above, as per the following options:

- If you chose to \textit{not} be notified by the principal investigator when the audio-recording of your interview is destroyed, and to \textit{not} review and approve your anonymized interview transcript, your \textbf{final opportunity to withdraw from the research will be at the end of their face-to-face interview.}
- If you chose to be notified by the principal investigator when the audio-recording of your interview is destroyed, but to \textit{not} review and approve your anonymized interview transcript, your \textbf{final opportunity to withdraw from the research will be when you are notified the audio-recording has been destroyed.} Following the destruction of the audio-recording, interview transcripts will be anonymized and assigned a random numeric code for analysis, and will no longer be able to be withdrawn from the research.
- If you chose to \textit{not} be notified by the principal investigator when the audio-recording of your interview is destroyed, but chose to review and approve your anonymized interview transcript, your final opportunity to withdraw from the research will be when you review and/or have approved your transcript. Following the anonymized transcript review,
transcripts will be assigned a random numeric code for analysis, and will no longer be able to be withdrawn from the research.

SECTION 2: USE OF PSEUDONYMS:
The final research publication will use pseudonyms to present direct quotes and compelling insights shared by participants. If a pseudonym is not selected by a participant, one will be assigned prior to analysis. The principal investigator will be able to re-identify any participants who have selected their own pseudonym, but shall never disclose any participants’ identities, involvement, and/or use of a pseudonym within this research. No record linking participants’ identities, informed consent forms, and/or data collected via interviews will be developed or retained at any point in time, unless explicitly limited to participants’ selection of a pseudonym within the space provided below.

If you wish to select a pseudonym for use within the final research publication, please specify a first and last name:

Pseudonym first name: ________________________________

Pseudonym last name: ________________________________

SECTION 3: RESEARCH RESULTS:
The findings from this research will be shared with local community and social service agencies that provide support to survivors of trauma or adversity and individuals at-risk, the Resilience Research Centre (Resilience Research Centre, n.d.), and Royal Roads University upon its completion (projected for October, 2019).

Please specify whether you would like to receive an executive summary and/or full publication of the research upon its completion.

___ Yes, I would like an executive summary of the findings from this research.

___ Yes, I would like a full publication of this research.

Name: ____________________________________________

Phone: ____________________________________________

Email: ____________________________________________

Mailing Address: ___________________________________
SECTION 4: INFORMED CONSENT

By completing and returning this informed consent form to the principal investigator, you are indicating you have read and understood the terms outlined within this informed consent form in full, and are consenting to participate in the research in accordance with these terms.

**Participant name (please print):**

____________________________________  **Principal investigator (please print):**

____________________________________

Signature:                      Signature:

____________________________________

Date:                          Date:
Appendix B – Interview Guide

This is not a verbatim interview protocol or exhaustive list of all questions that may have been asked during in-depth interviews with community and social service professionals. The following open-ended interview questions were posed to all participants, and non-invasive relevant follow-up questions were used to clarify responses, prompt elaboration, and facilitate a dialogue on the research topic.

BACKGROUND

- What is your profession and current job title?
- How long have you been working in this profession?
- What is your educational and professional background related to this profession?

TRAUMA in PROFESSIONAL PRACTICE

- How do you define trauma or adversity as a professional in your field?
- How often do you encounter clients who have been affected a trauma or adversity?
  - What kind of services or support do you provide to these clients?
  - What are the primary needs or concerns that you regularly try to address when working with clients affected by trauma or adversity?

TRAUMA as a CONCEPT

- Are there any factors or circumstances, whether they be pre-existing, related to the trauma or adversity itself, or its aftermath or impact, that make it harder for people to overcome these experiences, or exacerbate their impact? How so?
- Are there any factors or circumstances that are especially beneficial or helpful to survivors of trauma or adversity, or factors that support healing or recovery? How so?
- What are some of the major needs of survivors of trauma or adversity in terms of being able to overcome their experiences or circumstances?
- What do survivors of trauma or adversity seem to struggle with the most?

RESILIENCE as a CONCEPT

- How do you define resilience as a professional in your field?
  - Do you view resilience as the same as fully recovering or healing from experiences of trauma or adversity?
    - Do you think it’s possible to completely heal or recover from experiences of trauma or adversity?
  - Can resilience manifest differently during the immediate aftermath of trauma or adversity, compared to medium- or long-term manifestations of resilience?
  - Is it possible to be both resilient and deeply negatively affected by trauma or adversity at the same time?
  - Is resilience manifest differently among different people or contexts?
  - Do you view resilience as a single trait or characteristic, or could resilience involve multiple characteristics or capacities?
  - Do you think it is possible to build or develop resilience, regardless of any kind of pre-existing disposition? If so, how?
Do you think resilience is influenced more heavily by internal factors within people, or external factors like the environment, context, or other life circumstances? Why?

Can resilience be influenced by both internal and external factors? If so, how?

RESILIENCE in PROFESSIONAL PRACTICE

- Based on your professional experiences, how prevalent would you estimate resilience is among survivors of trauma or adversity you have encountered?
- What kinds of things do you think help develop or foster resilience following trauma or adversity? How so?
- Is resilience something that you or others in your profession take note of in dealings with the clients you encounter?
  - As a professional, how do you assess resilience? These measures could include formal assessments or informal measures such as observations.
  - Are there any viewpoints, values, attitudes, beliefs, behaviours, skills, resources, or other characteristics among survivors of trauma or adversity that you tend to associate with resilience?
- Throughout your professional experience, how often would you say resilience is incorporated as a component of programs or services, or as a desired outcome or goal?
  - How do you foster or incorporate resilience in your work with clients?

SOCIAL SUPPORT

- How does social support, such as that from family, friends, or the community, impact the wellbeing of survivors of trauma or adversity?
- What role does social support play in fostering resilience?
  - How important do you think it is? Why?
  - Is there a certain source of social support, or type of social support that you think might be more important or more beneficial to survivors of trauma or adversity, or to fostering resilience? Why?
- What about a lack of social support: How might social isolation or frequent negative social exchanges impact survivors of trauma or adversity?
  - What kind of impact might this have on resilience or on healing and recovery?

COMMUNITY SUPPORT

- How can people and communities better support those affected by trauma or adversity?
  - How would this help?
- How can people and communities foster resilience following trauma or adversity?
  - How would this help?

CONCLUSION

- Is there anything else you think I should know about the role professionals play in supporting survivors of trauma or adversity within the community?
- Is there anything you think that others should know or try to understand about trauma or adversity, or about survivors of trauma or adversity?
- Is there anything else you want to share with me about resilience following trauma or adversity, or the role of community and social support?
Appendix C – Deductive ‘a priori’ Codes

Table 6

*Deductive a priori codes*

<table>
<thead>
<tr>
<th>Category</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions of trauma and adversity</td>
<td>• C-PTSD</td>
</tr>
<tr>
<td></td>
<td>• Historical trauma</td>
</tr>
<tr>
<td></td>
<td>• Intergenerational trauma</td>
</tr>
<tr>
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<td>• Subjective perceptions and clinical thresholds</td>
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<tr>
<td>Trait-based resilience</td>
<td>• Person-centred variables and characteristics</td>
</tr>
<tr>
<td>Outcome-based resilience</td>
<td>• Prevalence of resilience</td>
</tr>
<tr>
<td></td>
<td>• Pre- and post-traumatic event functioning</td>
</tr>
<tr>
<td>Process-based resilience</td>
<td>• Coexistence with distress</td>
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<td></td>
<td>• Distinction from recovery</td>
</tr>
<tr>
<td></td>
<td>• Nonlinearity</td>
</tr>
<tr>
<td>Dimensions of diversity</td>
<td>• Diversity</td>
</tr>
<tr>
<td></td>
<td>• Individuality</td>
</tr>
<tr>
<td></td>
<td>• Gender identity/sexual orientation</td>
</tr>
<tr>
<td></td>
<td>• As risk and/or protective factors</td>
</tr>
<tr>
<td></td>
<td>• Population-specific norms and trends</td>
</tr>
<tr>
<td>Continuum of risk and protection</td>
<td>• Chronic/recurrent exposure and life course accumulation</td>
</tr>
<tr>
<td></td>
<td>• Childhood exposure, ACES, and C-PTSD</td>
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<tr>
<td></td>
<td>• Elements of exposure (proximal vs. distal impact, resource loss)</td>
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<tr>
<td>Impact of the social-ecological environment</td>
<td>• On risk and/or protective factors</td>
</tr>
<tr>
<td></td>
<td>• Equifinality</td>
</tr>
<tr>
<td></td>
<td>• Macro-level factors (e.g., sociopolitical, socioeconomic, and</td>
</tr>
<tr>
<td></td>
<td>sociocultural conditions)</td>
</tr>
<tr>
<td>Community and social support</td>
<td>• As a source of relational and material resources</td>
</tr>
<tr>
<td></td>
<td>• As shaped by the social-ecological environment</td>
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<td></td>
<td>• As resource factors (e.g., main effects) versus protective factors (e.g., buffering effects)</td>
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<tr>
<td></td>
<td>• Relationship to self-efficacy and social competence</td>
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<tr>
<td></td>
<td>• Relationship to resilience and/or recovery</td>
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<td></td>
<td>• Social learning and modeling</td>
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<tr>
<td></td>
<td>• Psychology of place, sense of community, communal mastery, and</td>
</tr>
<tr>
<td></td>
<td>sociocultural or community engagement and recreation</td>
</tr>
<tr>
<td>Service design</td>
<td>• Trauma-informed</td>
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<td></td>
<td>• Evidence-based</td>
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<tr>
<td></td>
<td>• Specificity and inclusivity (e.g., gender-, trauma-, and/or</td>
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<td></td>
<td>cultural-specificity/inclusivity)</td>
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<td></td>
<td>• Outreach and stakeholder collaboration</td>
</tr>
<tr>
<td></td>
<td>• Capacity-building and continued education</td>
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<tr>
<td>Approach considerations</td>
<td>● Strengths-based approaches</td>
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</table>
### Appendix D – Analysis Codes & Themes

#### Table 7

**Themes, categories, and codes**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>Resilience as a three-part construct</td>
<td>Trait-based resilience</td>
<td>• Universal</td>
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<td></td>
<td>• Related traits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Innateness</td>
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<td></td>
<td></td>
<td>• Development over time</td>
</tr>
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<td></td>
<td>Outcome-based resilience</td>
<td>• Prevalence</td>
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<td></td>
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<td>• Silver-lining to trauma</td>
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<td></td>
<td>Process-based resilience</td>
<td>• Phases/stages</td>
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<tr>
<td></td>
<td></td>
<td>• Ongoing and nonlinear</td>
</tr>
<tr>
<td>Secondary conceptual considerations</td>
<td>Definitions of trauma and adversity</td>
<td>• Snowball effect of life course accumulation, triggers, and re-traumatization</td>
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<td></td>
<td></td>
<td>• C-PTSD, ACEs, and gendered trauma</td>
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<td></td>
<td>• Militarization/romanticization of trauma and PTSD</td>
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<td>Dimensions of diversity</td>
<td>• Individuality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Gender identity and/or sexual orientation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diversity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Intersectionality</td>
</tr>
<tr>
<td></td>
<td>Distinction between and coexistence with related concepts</td>
<td>• Distinction from recovery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• As a component of recovery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Potential for recovery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Coexistence with distress</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ongoing, nonlinear trajectories</td>
</tr>
<tr>
<td>Continuum of risk and protection</td>
<td>Risk and protective factors</td>
<td>• Duality</td>
</tr>
<tr>
<td></td>
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<td>• General risk and protective factors</td>
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<td></td>
<td></td>
<td>• Comorbidity, complex trauma, and ACEs as risk factors</td>
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<td>• Community and social support as resource factors (e.g., main effects) and protective factors (e.g., buffering effects)</td>
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<tr>
<td></td>
<td></td>
<td>• Stigma, negative social interactions, and inadequate social support as risk factors</td>
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<td></td>
<td></td>
<td>• Social isolation as a risk and protective factor</td>
</tr>
<tr>
<td>Community and social support</td>
<td>Social-ecological environment</td>
<td>• Person-environment (PxE) interactions</td>
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<tr>
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<td></td>
<td>• Macro-level factors (e.g., sociopolitical, socioeconomic, and sociocultural conditions).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Equifinality</td>
</tr>
<tr>
<td></td>
<td>Reservoir of relational and</td>
<td>• Complimentary networks of support (e.g., friends, family, professionals, community)</td>
</tr>
</tbody>
</table>
| Material Interpersonal Resources | • Relatable support, peer-to-peer support, and shared experiences  
• Sociocultural and community engagement and recreation  
• Social isolation/lack of support as a lack or loss of resources  
• Basic needs and safety, security, and stability of interpersonal resources |
| Social Competence | • Social competence of survivors and individuals at-risk  
• Social competence of external social actors  
• Psychoeducation, mental health literacy, and stigma  
• Social isolation and negative social interactions  
• Feedback loops for social learning and modeling  
• Self-efficacy and communal mastery |
| Service Considerations | Continuum of Care | • Complimentary trauma-informed multidisciplinary services  
• Practical, advocacy, and criminal justice supports  
• Mental health supports and crisis intervention  
• Gender-specific and peer-to-peer supports  
• Timely access to trauma-informed community and social services  
• Outreach, stakeholder collaboration, and need for additional resources |
| Approach Considerations | Strengths-based Approaches | • Intuitive understandings and recognition of existing resilience  
• Professional competencies and strengths-based language  
• Rapport-building and lived experience  
• First-time disclosure and self-identification  
• Hope, perspective, and sense of self or identity  
• Self-efficacy, agency, and control  
• Sense of safety, security, and stability |
| Burn out and Professional Resilience | • Burn out  
• Compassion fatigue and vicarious trauma  
• Balanced empathy  
• Impacts on professional competence  
• Self-care and caring for caregivers  
• Professional resilience |
## Appendix E – Participant Backgrounds

### Table 8

**Participant backgrounds**

<table>
<thead>
<tr>
<th>Participants*</th>
<th>Job Title</th>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joanne Hamilton</td>
<td>Executive Director, homelessness and community-based residential shelter.</td>
<td>40+ years of experience working in senior roles in non-profit organizations serving women and girls; briefly worked as a provincial government policy analyst for an anti-domestic violence prevention program. Education: Undergraduate nursing degree, undergraduate bachelor of arts degree double majoring in psychology and sociology.</td>
</tr>
<tr>
<td>Terri Linwood</td>
<td>Senior Coordinator of Community Programs, homelessness and community-based residential shelter.</td>
<td>10+ years of experience delivering programs to youth and adults who are homeless, criminalized, or marginalized. Education: Addictions counselling and social service work diplomas.</td>
</tr>
<tr>
<td>Caroline Anderson</td>
<td>HR, Fundraising, &amp; Communications Coordinator, homelessness and community-based residential shelter.</td>
<td>3+ years of experience through various placements, internships, and employment contracts with multiple women’s and youth homeless shelters, domestic violence shelters, mental health facilities, and a community-based residential shelter. Education: Undergraduate social work degree, child and youth social service work diploma.</td>
</tr>
<tr>
<td>Marie Stanley</td>
<td>Senior Residential Case Worker, homelessness and community-based residential shelter.</td>
<td>3+ years of experience; previous experience as a Residential Case Worker within a community-based residential shelter. Education: Addictions and mental health counselling diploma.</td>
</tr>
<tr>
<td>Claire Simpson</td>
<td>Mental Health Worker and Reporting Centre Case Manager, homelessness and community-based residential shelter.</td>
<td>3+ years of experience; resilience-building program coordinator. Education: Social service work diploma, undergraduate degree in psychology, completing a graduate degree in counselling psychology.</td>
</tr>
<tr>
<td>Angela Pearson</td>
<td>Registered Nurse (RN), regional in-patient mental health centre</td>
<td>4+ years of experience working on the dual diagnosis floor of a regional in-patient mental health centre. Education: Undergraduate nursing degree.</td>
</tr>
<tr>
<td>Cheyenne Greenside</td>
<td>Project coordinator, local women’s shelter</td>
<td>7+ years of experience as a crisis counsellor with sex workers and survivors of sexual assault; lead project support person for a local women’s shelter. Education: Undergraduate degree in psychology.</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Experience and Education</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sarah Kolcheck</td>
<td>Youth Mental Health Worker, local mental health association.</td>
<td>20+ years of experience working in youth services; 13+ years of experience working at a local branch of a nationally recognized mental health association. Education: Social service work diploma, completing an undergraduate degree in psychology.</td>
</tr>
<tr>
<td>Natasha Kirkwood</td>
<td>Addictions Worker, local mental health association.</td>
<td>2+ years of experience working at a local branch of a nationally recognized mental health association. Education: Graduate degree in social work.</td>
</tr>
<tr>
<td>Lori Peterson</td>
<td>Mental Health and Addictions Counsellor, local mental health association.</td>
<td>13+ years of experience working at a local branch of a nationally recognized mental health association. Education: Addictions counselling diploma.</td>
</tr>
</tbody>
</table>

*All participant first and last names have been replaced with pseudonyms selected by participants or assigned by the principal investigator.*