A Closer Look: Case Studies in Trauma Survivorship

McKenna K. Minarcin

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Thesis Director: Joan A. Reid, Ph.D.
Associate Professor, College of Behavioral and Community Sciences

Judy Genshaft Honors College
University of South Florida

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McKenna K. Minarcin

has been approved by the Examining Committee
on May 4, 2021
as satisfying the thesis requirement
of the Judy Genshaft Honors College

Examining Committee:

_____

Thesis Director: Joan A. Reid, Ph.D.
Associate Professor, College of Behavioral and Community Sciences

_____

Thesis Committee Member: Jay L. Michaels, Ph.D.
Assistant Professor, College of Arts and Sciences

Abstract

This paper focuses on a case study analysis of several traumatic experiences as told by survivors. Through this case study approach, this paper attempts to humanize the often heavily statistical world of trauma research. The first portion of this thesis is comprised of research surrounding current trauma research and coping mechanisms (both positive and negative) associated with trauma response. These methods include both traditionally accepted practices and alternative treatments, as well as the financial, emotional, and physical implications of these treatment methods. The second portion of this thesis is comprised of the narratives previously mentioned, which were each obtained through individual interviews. Names and other identifying details have been changed for anonymity.

Part One: Introduction, Background, and Method

Introduction

Trauma and its effects have been studied in Western society for more than one hundred years. The relationship between trauma and mental illness was first investigated in the late 19th century by French psychologist Jean Martin Charcot; Charcot was heavily involved in the treatment of "hysteria" in women (Ringel, 2012). Since then, with the 1980 inclusion of PTSD into the Diagnostic and Statistical Manual of Mental Disorders (DSM)- among other recognitions- trauma research has evolved into its current state. The newest DSM lists well over one hundred recognized diagnoses, and demand for psychologists continues to increase (Ringel, 2012). However, as the field of trauma psychology research continues to advance, its efficiency can at times be its Achilles- at what point does the effectiveness of mass data analysis cause a loss of remembrance of the individual?

When studying large quantities of data from mass data sets pertaining to trauma, it can be easy to forget that each numerical value represents an individual experience. This paper serves as a reminder of that personable level of research- yes, the field of trauma research has improved in efficiency and accuracy, but its roots in serving the health and wellbeing of the individual must not be forgotten. To ensure this "reminder", this paper includes a general overview of the field's understanding of the effects of trauma (intended to generally inform), followed by three case study-style interviews. Each of these stories, graciously shared by anonymous voluntary interviewees, reminds us of the real people we seek to help.

Background

The following is a general overview of current research surrounding trauma and its effects. Specifically, this section serves to inform the reader of both positive and negative short- and long-term effects of trauma, both consciously and subconsciously. A general understanding of the definition of post-traumatic stress disorder (PTSD) is assumed.

Negative Effects of Trauma and Unhealthy Coping Tactics

Research surrounding trauma has revealed a variety of potentially negative effects, including higher rates of alcohol and drug usage, behavioral challenges, and criminal activity. Although not all survivors of trauma will follow these trends, research has linked these behaviors as being more prevalent in survivors.

Individuals with a history of trauma have a higher rate of alcohol consumption. A 2020 study on alcohol consumption showed that, among 91 participants with some history of trauma, participants reported drinking an average of 10.64 standard drinks per week (Luciano, Acuff, Mcdevitt-Murphy, & Murphy, 2020). By using a self-survey method to assess these drinking episodes and the emotions that participants associated with them, the study was also able to demonstrate a correlation between drinking and feelings of depression and/or anxiety. It is also important to note that these standard drinks were often consumed in very few sittings- participants were not spacing out their alcohol consumption, but rather drinking with the intention to achieve some level of intoxication. The study found that participants reported an average of 6.26 “alcohol problems” (intoxication or drinking to cope) in the month prior, which was coupled by a 49.9% report rate of feelings of depression and/or anxiety. Another 2020 study

discovered that feelings of guilt were a main motivator drinking in participants with a history of trauma (in this case, specifically trauma related to war) (Capone et al., 2020). Although the study only focused on the experiences of veterans, thus limiting the scope of this study, the concept of guilt as a motivator can be applied cross-sectionally. This higher rate of trauma-related alcohol consumption in survivors is concerning and will be further explored in the narrative portion of this thesis.

Higher rates of illicit and/or illegal drug use have also been linked to survivors of trauma. However, although recent studies show a direct correlation between experiencing trauma and abusing alcohol, the same correlation is not true when applied to trauma and drug usage. A 2020 study found that the experience of trauma itself did not predict drug use in adult hood; "Instead, coping strategy predicted severity of drug use and being a problematic drug user." (Ayres, 2020). The study then emphasizes the importance of early intervention with children who experience trauma, as well as the importance of educating trauma sufferers on effective and healthy coping strategies in "trauma-informed treatment". Each of the participants in this study that had experienced trauma before the age of 18 and had little to no healthy coping knowledge showed to be significantly more likely to engage in problematic drug-related behavior as compared to a control group of individuals that had experienced childhood trauma and were educated on how to cope with it. In addition to drug abuse, although both groups had similar traumatic experience (both in number and severity), individuals without knowledge of effective coping strategies showed higher rates of behavioral avoidance and cognitively avoidant approaches to coping as compared to individuals with knowledge of such coping strategies. In the study's conclusion, the author explained that cognitively avoidant approaches to coping could predict drug use in adulthood with a 71.8% accuracy. Thus, it can be assumed that trauma

itself does not cause drug use, but rather an unhealthy response to trauma itself; in other words, unhealthy coping strategies can directly lead to drug use. A similar 2019 study suggested that, in addition to unhealthy coping mechanisms, lack of emotional acceptance of the trauma contributes heavily to drug abuse in adulthood (Woodward, et at., 2019). In this study, out of 50 participants, symptoms of PTSD were most severe in those who claimed to use distraction as a coping strategy. In addition, difficulty expressing or resolving negative emotions also correlated with more intense cases of PTSD, which again shows the importance of emotional education in young children (especially those that have experienced trauma in some form). The study notes that this phenomenon can be explained through the emotional processing theory, which suggests that fear can present itself in an individual as a result of an unwillingness to experience negative emotion, thus causing a trauma-avoidant outlook. This avoidant response can lead to a search for methods of nullifying or "drowning out" such negative emotions (such as those related to PTSD and anxiety, which trauma sufferers often experience), which can cause a reliance on drugs. While these avoidant strategies may cause an individual to feel temporary relief, the same 2019 study posited that "theory and empirical evidence suggest that nonacceptance of negative emotions exacerbates emotional distress". In other words, emotionally avoidant behavior may provide short-term benefits, but only cause the individual to feel worse over time. In individuals with PTSD or PTSD symptoms, this avoidant behavior and escapism may lead to a worsening of PTSD symptoms in particular. However, more research on addictive behavior in trauma-exposed youth is needed before concrete assertions are made.

Survivors of trauma often experience strained social and personal lives as a result of their trauma response. Until recently, it was assumed that survivors of trauma often struggle with poor social lives as a result of attitude or irritability. Recent research has shown, however, that this

asocial behavior is more likely due to impaired reward processing as a result of avoidant trauma response. A 2020 study discovered that those who had experienced trauma were more likely than those who had not to sacrifice reward if a risk was present; survivors were more likely to refrain from risk-taking through maladaptive avoidance (Weaver et al., 2020). This pattern of avoidance can be applied to the relationships of trauma sufferers, as a social setting or personal connection can appear to be too risky for someone with PTSD, thus causing such an individual to refrain from interpersonal connections ("sacrificing reward"). As summarized from the aforementioned study, "when avoidance is advantageous (congruent phase), individuals with PTSD show increased task performance, whereas when avoidance is maladaptive (conflict phase), individuals with PTSD show increased sacrifice of reward." Although the quality of a relationship and/or the level of avoidance of interpersonal connections may seem immeasurable by statistical standards, the recent development of new scaling techniques has been able to quantify the disparities between the relationships of a survivor and the relationship of a non-survivor (someone who has not undergone trauma). In 2003, the Trauma Attachment and Belief Scale (TABS) was developed in an attempt to evaluate the effect of trauma on interpersonal relationships. This belief scale focuses on five main areas of schema disruption: safety, trust, intimacy, control, and esteem. A 2016 study further explored TABS by applying the scale to service members and their partners- these findings showed more challenges to the pillars of safety and trust in the relationships of the veterans in the study, thus supporting the idea that survivors of trauma struggle to find and maintain strong relationships (Buchanan, Mccubbin, & Adesope, 2016). This furthers the idea of "reward-sacrificing" behavior- no interpersonal relationships can be viewed as easier than the risk of further trauma for those that have already suffered some form of trauma. Thus, the development of a "loner" personality may occur- survivors of trauma may draw inward

emotionally and self-isolate themselves, thus causing a lack of a social support system. Even in cases of trauma sufferers that act out rather than withdraw, research has shown that avoidance-targeted therapeutic tactics to change such behavior are more effective than other methods. A 2018 study found that, out of 414 participants, “experiential avoidance was a significant mediator of the association between childhood trauma and problem behavior”, and thus further recommends that avoidance and mindfulness be explicit targets of intervention tactics when a survivor of trauma is exhibiting problem behavior (Roche, Kroska, Miller, Kroska, & O'hara, 2018).

In addition to avoidant behavior, research suggests that survivors of trauma (specifically childhood trauma) are at a higher risk of criminal behavior in adolescence and adulthood. It is important to note, however, that- similar to drug use- being a survivor of trauma does not automatically translate to committing an offense, and there is very little data on the severity of offenses committed by survivors of trauma. A cross-sectional 2018 study surveyed 200 (100 male and 100 female) inmates in Istanbul and assessed their experiences of trauma and family psychiatric history through interviews (Altintas & Bilici, 2018). This study concluded that its findings “indicate a potential link between childhood traumatization and criminal behavior in terms of subsequent offending, but not in terms of severity of the subsequent offense”, thus suggesting that survivors do make up a large percent of the current global prison population and thus commit some form of offense at a disproportionately high rate. A similar 2006 study was conducted in Germany in which such a correlation was also suggested (Driessen, Schroeder, Widmann, Schönfeld, & Schneider, 2006). This study also discovered a high rate of personality disorder among inmates that are often a result of trauma, suggesting that these disorders may be at fault for the criminal behavior rather than the trauma itself. Thus, the importance of healthy

coping strategies must be stressed, as these disorders are manageable in an effective way when treated correctly. From this, although far more research is needed, it can be assumed that trauma survivors are at a higher risk of criminal behavior.

Survivors of trauma are at a higher risk of most avoidant and criminal behaviors, including alcohol and drug use, as well as avoidant and/or criminal behavior. Research shows that the trauma itself does not cause this behavior; rather, a lack of healthy and helpful coping tactics is more likely to directly impact or cause antisocial habits.

Positive Outcomes After Trauma and Healthy Coping Tactics

Although undergoing trauma is an inherently negative experience, there are therapeutic tactics and cognitive strategies that may lead to a more positive outcome, including cognitive behavior therapy, cognitive processing therapy, and eye movement desensitization and reprocessing. There are many cognitive strategies beyond those discussed here; the therapies listed reflect the most popular (most used) treatments for PTSD currently.

Cognitive behavioral therapy (CBT) is perhaps the most obvious strategy when coping with trauma. In cases where a survivor of trauma suffers from subsequent PTSD, some form of traditional therapy is usually implemented. In 2017, a study specifically related to trauma survivors with both PTSD and borderline personality disorder (BPD) found that cognitive behavioral therapy was associated with improvements in PTSD symptoms and outperformed other methods used to treat PTSD (Kredlow et al., 2017). Overall, the study found cognitive behavioral therapy to have a “large effect size” on PTSD symptoms with results lasting up to a year after the cessation of treatment. A 2020 study found that phase-oriented treatment for PTSD symptoms had a similarly large effect size (Corrigan, Fitzpatrick, Hanna, & Dyer, 2020). In each

study, the large effect size stayed constant when the sample size was both expanded and reduced, thus portraying these treatment approaches as highly reliable. This suggests that a phase-oriented CBT approach to PTSD symptoms is highly effective, but more research is needed in this area specifically. A specific kind of cognitive behavioral therapy that has shown to be effective in treating PTSD is stress inoculation therapy (SIT). Stress inoculation therapy focuses on controlling the body's response to stress rather than the stress itself. Although this approach presents certain issues (namely treating the symptoms of the problem rather than the problem itself), there is a large amount of evidence to support the use of stress inoculation therapy as a treatment for PTSD. A 2019 study found that SIT led to significant reductions in both PTSD symptoms and depression, as well as increased perceived stress tolerance and social and occupational functioning. (Jackson, Baity, Bobb, Swick, & Giorgio, 2019). Although this is a preliminary study, these results seem to show promising data surrounding the use of stress inoculation therapy in sufferers of PTSD. However, this kind of treatment can be expensive and difficult to locate (depending on geographic location and nationality), thus limiting the scope of these approaches. It is crucial that efforts are made to make these treatments more available to trauma survivors both financially and physically, as the cycle of abuse and incarceration will continue unless methods of intervention are implemented. This cyclical pattern has been shown previously as related to criminal activity and substance abuse. Contrastingly, stress inoculation therapy can be performed in solo sessions (due to the focus on body response control), which makes SIT a slightly more accessible form of cognitive behavioral therapy. However, in order to conduct solo sessions of stress inoculation therapy, an individual must understand what SIT is and how to conduct a session, which requires some form of education or information on the

matter. Thus, widespread educational efforts surrounding CBT are still needed globally to ensure the effective treatment of PTSD and other trauma-related disorders.

Another type of therapy that has proven to be useful in treating PTSD is cognitive processing therapy (CPT). Traditionally, cognitive processing therapy follows a 12-week course of treatment in which the administrator and patient(s) meet in hour- to hour-and-a-half-long sessions. CPT involves a dual approach- first, the patient will discuss his or her trauma in detail with his or her therapist, and then the patient will write in detail about the trauma in question. This dual approach causes reinforcement within the patient regarding exposure to their trauma, and thus can significantly lessen the effects and symptoms of PTSD. Cognitive processing therapy has also been shown to help survivors reduce levels of self-blame and guilt, as these emotions are often associated with PTSD and trauma. Research has shown that, by lessening feelings of self-blame and guilt, survivors can also ease the severity of PTSD and trauma-related symptoms. A 2020 study showed that, while undergoing cognitive processing therapy, a group of active-duty military personnel with PTSD were able to significantly lessen both their PTSD symptoms and their levels of self-blame (Dillon et at., 2020). This study also showed that improvements in prior PTSD preceded improvements in prior self-blame, and that improvements in prior self-blame also predicted improvements in prior PTSD, thus highlighting the dynamic relationship between guilt and trauma. Thus, the concept of cognitive processing theory is inherently supported in treating PTSD, as CPT is intended to improve feelings of self-blame, and improvements in self-blame have been shown to preceded improvements in PTSD symptoms. A second 2013 study (also following veterans, but focused on veterans with a history of sexual trauma of some kind) also found that cognitive processing therapy reduced symptoms of PTSD, and thus concluded that CPT was an “effective treatment” for PTSD (Surís, Link-Malcolm,

Chard, Ahn, & North, 2013). In both of these studies, follow-ups after several months found stable levels of symptom reduction, thus suggesting that cognitive processing therapy can be as effective in the long-term as it is in the short-term. However, the access to CPT may be limited by cost and location, as is the case with other traditionally accepted therapies. Thus, efforts should be made in the future to allow greater financial and physical access to cognitive processing therapy, as it is (perhaps) one of the most promising therapies mentioned in this thesis.

Eye movement desensitization and reprocessing (EMDR) is based on the idea that an individual's negative responses to distressing stimuli are a result of unprocessed memories and emotions, and thus focuses on asking the patient to recall or talk about such stimuli while undergoing some form of bilateral stimulation (often in the form of eye movements, as the name suggests). EMDR has been shown in several cases to be effective in treating PTSD and reducing trauma-related symptoms. A 2019 study found improvements in the brain connectivity and PTSD scale scores, thus suggesting that EMDR can be effective in reducing the severity of PTSD symptoms (Santarnecchi et al., 2019). A second 2017 study also discovered that, following EMDR therapy, patients experienced an increase in gray matter density, thus suggesting that EMDR can cause structural changes and improvements in the brain (Boukezzi, El Khoury-Malhame, & Auzias, 2017). More specifically, these changes in gray matter density were in areas associated with emotional regulation, thus suggesting that EMDR can improve overall coping behaviors and emotional control through changes in gray matter density. EMDR also appears to be a feasible treatment for PTSD in those with a personality disorder; a 2019 study found "a significant reduction in the symptoms of PTSD, dissociation, and insomnia" after patients with personality disorders underwent EMDR treatment (Slotema, Van Den Berg,

Driessen, Wilhelmus, & Franken, 2019). Thus, this therapy does not present any obvious challenges to those with both a PTSD diagnosis and a personality disorder that might be resistant to other therapies. In addition, after the EDMR treatments, 40% of patients in this 2019 study scored below the threshold of a PTSD diagnosis, thus supporting the idea that EDMR can drastically improve PTSD symptoms. However, like cognitive behavioral therapy, behavior processing therapy, and other traditional therapies, EDMR can be expensive and difficult to receive for those who live in rural or relatively undeveloped areas. This makes EMDR an effective treatment only for those that can both afford to receive the treatment and travel to the set location. Thus, efforts should be made to include EMDR (among other medically accepted treatments) in insurance and payment plans and to make EMDR therapy more widely available globally.

Another promising treatment for PTSD is prolonged exposure therapy (PET). Prolonged exposure therapy involved eight to fifteen sessions of approximately ninety minutes each and focuses on helping survivors of trauma combat avoidance. This direct targeting of avoidant behavior combats common trauma responses mentioned previously in this thesis, and thus directly combats the onset and severity of PTSD symptoms. Prolonged exposure therapy also involves breathing techniques, which allows for better management of anxiety in patients. A 2020 study found that patients undergoing prolonged exposure therapy showed a significant decrease in PTSD symptom severity and an increase in social support (Bourassa et al., 2020). This increase in social support was linked to a decrease in PTSD symptoms, supporting the notion that social support and a non-avoidant coping approach can improve PTSD severity. This increased social support as a result of prolonged exposure therapy also combats the “loner” personality development often seen in survivors of trauma (associated with the risk-avoidant and

reward-sacrificing behavior previously mentioned), and thus both encourages survivors to face their trauma and engage in social behavior. A 2018 study also showed promising results for PTSD as a result of prolonged exposure therapy- after receiving this treatment, a sample of active duty military members showed significant decreases in PTSD symptoms and depression (Brown et al., 2018). Prolonged exposure therapy was also linked to an increase in trauma cognition and processing, thus suggesting that prolonged exposure therapy can also help survivors to better process and come to terms with their experiences. In addition, in this study, patients experienced result stability over a six-month period, thus suggesting that prolonged exposure therapy can lead to long-term improvements in PTSD symptoms.

In addition to traditional therapy, meditation has been shown to reduce PTSD and anxiety symptoms in several cases. A 2012 article explains meditation as "developing a different relationship with or greater awareness of the mind" and explains that meditation is meant to achieve a "nonjudgmental stance", which may help trauma survivors overcome their experiences (Lang et al., 2012). It should be acknowledged, however, that the use of meditation as a treatment for PTSD and other trauma-related disorders is not clinically proven to be effective, and instead is viewed by most as a "promising" treatment possibility. A 2016 meta-analysis of the effect of meditation on PTSD symptoms found that meditation appeared to reduce the severity of such symptoms, but the authors acknowledge the lack of research in the area and thus cannot conclude that meditation is effective in treating PTSD (Hilton, Maher, Apaydin, & Colaiaco, 2016). Similarly, a 2013 clinical case series found transcendental meditation to be effective in three case studies, but ultimately conclude that it cannot be assumed that meditation is effective in treating PTSD (Barnes, Rigg, & Williams, 2013). Although the effects of

meditation appear to be positive, there is not a sound body of evidence to support this claim fully.

Progressive muscle relaxation (PMR) is a technique that allows an individual to relax individual muscle groups in a set order while inhaling and exhaling at a particular pace, thus relieving tension and slowing the breathing pattern. Progressive muscle relaxation has shown to be promising in relieving symptoms of PTSD (particularly anxiety), but there is not a complete body of evidence to support progressive muscle relaxation as an effective treatment for PTSD. Instead, progressive muscle relaxation is viewed- like meditation- as a promising possibility. There is at least some evidence to support the use of progressive muscle relaxation in relation to PTSD and anxiety, however. A 2018 study found that, in trials where progressive muscle relaxation was used, participants showed a "significant improvement" in anxiety score after treatments in conjunction with biofeedback and L-Theanine (Pangotra, Singh, & Sidana, 2018). In addition, a 2012 study found that PMR was effective in reducing the short-term stress of a high-tension group of college students (Dolbier & Rush, 2012). Although this particular study is focused on stress rather than anxiety or PTSD, the authors note that a small effect size was noticed in the reduction of anxiety as part of the students' stress reduction. Thus, it can be posited that the use of an anxiety-focused progressive muscle relaxation treatment could be effective in treating anxiety and PTSD. A 2006 study also showed promising data regarding progressive muscle relaxation (although in this particular study it is referred to as "autogenic training". After undergoing progressive muscle relaxation treatments, patients showed significant decreases in cardiac sympathetic nervous activity and significant increases in cardiac parasympathetic nervous activity (Mitani, Fujita, Sakamoto, & Shirakawa, 2006). Thus, the study concluded that progressive muscle relaxation (or autogenic training) can reduce the

nervous system activity of PTSD sufferers, and thus decrease feelings of anxiety and anxiety reactions in some cases. These results show PMR as a promising treatment of both PTSD and anxiety in both the emotional and physical senses. If progressive muscle relaxation is proven to be effective in treating PTSD and anxiety, the use of progressive muscle relaxation could allow survivors of trauma to find a non-pharmaceutical approach to recovery. By finding alternative treatments such as meditation and progressive muscle relaxation, trauma survivors are able to at least partially overcome the financial and geographical restraints of traditional therapy, as these alternative therapies (if proven effective) would allow individuals to perform therapy in their own location at a low cost. Meditation, in particular, requires little to no travel (one can meditate in their own home or workspace) and usually does not cost anything to practice (barring the use of guided meditation). Education is also important to promote the adoption of these treatments if proved to be effective in treating PTSD and other trauma-related disorders, as individuals will not be able to conduct meditative or progressive muscle relaxation sessions without some knowledge or information about these treatments. Thus, efforts should be made to increase the amount of easily available knowledge surrounding these treatments, as well as efforts to increase educational outreach surrounding alternative treatments (particularly those that subvert physical, financial, and emotional barriers surrounding the treatment of PTSD and other trauma-related disorders).

Trauma can be treated in a variety of ways. As trauma research develops, treatments like EMDR and PMR become more readily available at a lower cost. Although the effects of trauma are overwhelmingly negative, these treatment avenues should still be explored and celebrated. As mentioned previously, healthy coping tactics (therapy, meditation, etc.) seem to lead to healthier behaviors.

Method

This study uses qualitative methods by conducting a case study including three participants. Each participant was scouted through ordinary means (i.e., day-to-day interaction). Participants were from varying demographics; specific demographic information cannot be given to protect participants' identities. Interviews were conducted between the participants and the author; no licensed clinical psychologist was present.

Prior to being interviewed, participants were provided with a copy of the "Anonymous Survey: Paper Information Sheet" (see Appendix) which serves as a method of obtaining informed consent while continuing to safeguard personal information. Each interview followed a trauma-informed approach. Rather than utilizing a set list of questions, each participant was encouraged to share their experience to their comfort level. Guiding questions were used to maintain focus and to learn about emotional impact, but none of the interviews featured a standardized form of inquiry. Interviews ranged from one and a half hours to four hours, during which extensive notes (but no recordings) were taken with the consent of the interviewees. Although each of the three participants were provided the option to stop the interview at any time, none did.

Following the interview, the notes were used to construct written recounts of the experiences of the interviewees. Names, places, dates, and other personal details were changed or omitted to protect the identity of participants. Each participant reviewed and approved their individual narrative prior to publication or information sharing of any kind.

Part Two: Case Studies

The following narratives are the result of individual interviews with three trauma survivors. Sentences regarding the lives of interviewees stated as fact are done so with the permission of each participant. Names, locations, dates, and other identifying details have been changed or omitted to protect the anonymity of the respondents, but all other details are true and unaltered.

Kelly

Kelly describes herself as “careful”. She’s proficient in at least two martial arts, carries pepper spray, and has two locks on her door- three, if you count the safety lock she added to her deadbolt. She explains that her cautiousness is not compulsive; she’s simply protecting herself from a world that is unpredictable and often unsafe. She’s practical, and she speaks in a clear and condensed manner. Kelly likes stability, as it’s how she takes control back over her life- change came drastically and often during her childhood.

Kelly grew up in limbo. Her parents divorced when she was three and a fierce custody battle ensued, resulting in a parental agreement in which Kelly moved between houses every week. Kelly remembers watching her parents fight both before and after their separation- she does not recall witnessing physical abuse, but she remembers her parents “screaming” at each other (likely verbal abuse). Her parents’ now-separate households were polar opposite- during the weeks she spent with her mother, Kelly remembers very little supervision, but Kelly’s father heavily supervised her and controlled her during the weeks she spent with him. Over the next several years, Kelly’s mother would become more and more distant, eventually relinquishing her

custody over Kelly altogether. Kelly's father, on the other hand, involved himself in every aspect of her life. Kelly describes her father as a "complete control freak"- he changed her school, installed a tracker on her phone, reviewed her texts daily, and hand-picked her friends. It was during this time that he first began abusing her, Kelly explains.

Kelly describes the abuse as "starting quietly"- her father began to verbally abuse her at home around the time she started middle school. Her father never raised his voice at her in public or in front of family, so little suspicion was raised. When her father began physically abusing her during her early high school career, Kelly recalls feeling "trapped, alone, and filled to the brim with self-hatred". At the time, she blamed herself for her father's abuse- she believed that she had done something wrong, or that she was inherently "bad", so she somehow deserved the abuse she was experiencing. Kelly remembers being taught that she was being hurt because she deserved it, and due to this belief did not report the abuse, and peers and associates never independently noticed signs of the abuse. Kelly also describes beginning to self-harm during the time that she was abused by her father- she had been so convinced that she "deserved harm" that she had "begun to cause harm to" herself.

It was not until Kelly entered her junior year of high school that she began to consciously wonder if her father might be an abuser. Kelly learned about physical abuse in school, but she believed that she was different, as she "deserved" what her father did. When Kelly mentioned her father hitting her to a friend, her friend responded "so strongly" that Kelly felt as though she might need to report her father's behavior. After months of contemplation, Kelly reported her father to the authorities during her senior year of high school, resulting in his imprisonment and her removal from his household. Kelly, then with a full-time job and having turned eighteen earlier that year, was treated by her state as an adult, and thus began supporting herself.

Kelly remembers the first few months after her father was sentenced as “quiet”. She remembers feeling shameful- the police investigation had made a previously private trauma extremely public, leading her to feel vulnerable, uncomfortable, and exposed. She continued to self-harm, and although she was no longer restricted by her father in terms of his physical control, she still found herself self-isolating. Although she never turned to drugs or alcohol as a coping mechanism, she describes self-harming as “a drug in of itself”- for her, self-harming was addictive, and she found she could not stop. Despite this, she began seeing a therapist, as was suggested to her by one of the members of the prosecutorial team in her case. Kelly remembers therapy as her “lifeline”- once she graduated high school, work and therapy were the only two structured portions of her life. Therapy helped Kelly build her self-esteem; although she still struggles with self-deprecating thoughts, she no longer views herself as deserving harm, and she ceased self-harming completely approximately a year before the time she was interviewed. To better understand her psyche, Kelly has been voluntarily tested for PTSD and Generalized Anxiety Disorder and has been diagnosed with both. Kelly still sees the same therapist, but she now only feels the need to book monthly appointments.

Kelly describes her experience as “isolating”. She has attended support groups but has had little luck relating to other participants, as she has found few others with similar experiences. In addition to describing herself as “careful”, Kelly also describes herself as “truly happy, just a little lonely”- she’s still searching for a support group that she feels she can relate to. She has no contact with her father and is actively working on building her own independent career and character.

John

John describes himself as “slow”, albeit a bit jokingly. He is slow to anger, slow to judge, slow to trust, and “damn slow with the ladies”, as he quipped in his interview. He is a rule-follower, he loves his car “like a son”, and although he values family and friends, John says he is a true introvert at heart.

School was one of the few things John actively disliked as a teenager. He reiterated his self-described “slowness” when describing his schooling, stating that he never felt like the education system was built for people who learned in a fashion such as his. The disconnect John felt with school made college an unappealing option- even if he was accepted, he was opposed to more schooling. Thus, his interest in the military began to grow. John’s introverted nature made enlisting easy for him: his preference to spend time alone meant he did not have many friends or acquaintances tying him to America, so going overseas seemed like less of a drastic change. After his high school graduation, he enlisted as an infantryman in the Army and was deployed shortly thereafter.

John remembers his time overseas as “largely uneventful”. He spent most of his nine-month deployment running drills with his commanding officer or standing watch over their outpost, with the occasional Humvee supply run here and there. Until the last month of his deployment, John had not been in any active combat situations- only drills.

About three weeks before his scheduled return date, John’s outpost came under attack by a local resistance group. John vividly remembers waking up in the middle of the night to the sound of gunfire and feeling completely disconnected from reality. He describes the experience as “out-of-body” and recalls almost no distinct emotions from the event itself. After waking his bunkmates, John recalls leaving his tent with his assigned partner (he and his group were all

assigned a “battle buddy” to stay with during drills) with his weapon drawn. He remembers making his way through the small American camp and finding the rest of the camp locked in close combat with the rebel group. There, with the other soldiers, he began returning fire. He describes watching the death of his commanding officer in the crossfire and his battle buddy suffering a gunshot wound to the leg that would later cause a fatal sepsis infection. John explains that, at the time, it felt unreal. Even throughout the rebel group’s defeat and John’s return to America, he recalls feeling almost nothing- only numbness.

When John came back to the states, the injuries he had sustained caused him to leave the Army. He rented a small apartment, got a job in the security industry, and was seemingly stable, but he continued to experience complete apathy; John felt very little emotion towards anything. He began drinking at night, as his apathy meant that he struggled to feel tired enough to sleep. Then, John remembers, he started drinking in the mornings, too, and then he “was just drinking all the time”. To him, drinking made him feel similarly numb, but being drunk was at least a voluntary numbness. John lost his job due to his drinking but had enough money in savings to pay for rent and basic necessities for a few months.

Realizing that he had a dependence, John began attending a support group intended to assist alcoholics through recovery. The support group helped John to cut back his drinking so that he could provide for himself again. With this newfound sense of community, John was able to get a job that he enjoys, and he has since gotten married and adopted a retired service dog. He says he will never completely quit drinking as he “loves whiskey too much”, but he only drinks occasionally on weekends. He has never attended therapy or sought other forms of licensed treatment and has never received a diagnostic impression from a professional, but he believes

that he likely has post-traumatic stress disorder (PTSD). Although John has not sought conventional treatment, he has discussed his experience with other survivors and with his wife.

John described his emotions now as “having so much more color”- now, John feels a wider range of emotions on a greater dynamic scale. He struggles with nightmares, however, and has considered seeing a therapist or sleep specialist, but has not yet as he is (as previously mentioned) slow to trust people he does not know with personal details.

John remembers his commanding officer and his battle buddy as brothers. He describes the bond between men deployed together as “unbreakable” and still misses their brotherhood to this day. He visits their graves at least once a year.

Kevin

Kevin describes himself as “the class clown”. He can recite entire scenes from *Impractical Jokers* episodes and to this day carries a whoopee cushion in his pocket “just in case”. He says that he enjoys making others laugh above all else- even when it landed him in detention or led to disciplinary action at work, Kevin constantly played practical jokes for most of his adolescence. Kevin himself notes that, over time, these jokes became more reckless, eventually leading to Kevin’s theft of a coworker’s car. In his mid-twenties, Kevin was sentenced to jail time for charges related to vehicle theft.

Kevin remembers his time in jail “with a lot of hurt”. Almost immediately, Kevin was found by several other inmates to be “pretty”- he was young, attractive, and shorter in stature, making him an easier target for predatory behavior. Kevin describes being approached by different inmates on at least three separate occasions within his first week of incarceration, each offering him “protection” during his incarceration in exchange for sexual favors. Kevin explains

that he has always identified as heterosexual and was thus disinterested in the all-male prison population, and thus rejected the advances of the inmates. Kevin remembers two of the men he turned down as being polite, but one as being “aggressive and manipulative”. He recalls this man asking him repeatedly over the following two weeks to perform sexual acts. Eventually, the man also began groping Kevin during group activities. Although Kevin reported the behavior, Kevin describes the facility’s management as being “unresponsive”.

During his second month of incarceration, Kevin began spending his recreational hours in the library. Although Kevin was normally happiest in large groups (a self-named extrovert), he found himself gravitating towards the quieter atmosphere of the library often during his sentence. Reading allowed Kevin an escape from the jail environment and provided something to think about other than the sexual harassment of the inmate previously noted; Kevin describes books as a “portal to a better world”. However, due to the nature of the prison, the man that groped Kevin was able to discern his whereabouts and began learning when Kevin spent the most time in the library. During the end of Kevin’s second month of incarceration, Kevin recalls, the aforementioned inmate raped him during recreational hours in the library. Kevin remembers feeling violated and angry- Kevin was distraught not only that the assault had occurred at all, but more specifically that the assault had occurred in the library, Kevin’s safe space.

After the inmate raped Kevin, Kevin remembers becoming increasingly withdrawn. Although he had already decreased his social interactions by spending so much time in the library, he now found himself rarely leaving his cell. Kevin recalls having no friends, refusing calls from family, and eating alone at meals. This isolation also made him a target for beatings and further harassment- further traumatic events that left Kevin feeling “exhausted, but somehow furious at the same time”. Kevin found himself emotionally incapable of reporting the assault; he

felt too violated to share what had happened to him, and he felt too emotionally drained to seek help.

When Kevin was released from jail, he found it difficult to find work, and thus moved in with a family member. He remembers spending most of his time playing video games and using recreational drugs; Kevin describes losing hours of time to video games to distract from memories of the assault he underwent, as well as using marijuana and cocaine to numb the feelings of anger and violation he was experiencing. Eventually, the family member with whom Kevin resided gave Kevin an ultimatum: go to therapy or find somewhere else to stay.

Although this method was unorthodox and arguably immoral, Kevin remembers the requirement of therapy as "a blessing". If he had not begun seeing a therapist, Kevin believes he would have likely been rearrested on drug charges or overdosed on cocaine. Shortly after beginning therapy, Kevin's therapist began to encourage him to start a drug rehabilitation program; Kevin's cocaine dependence had developed into self-described addiction, which caused Kevin to use dangerously high volumes of cocaine at a time. Health problems related to his heavy drug usage forced Kevin to "get real"- Kevin came to terms with the gravity of his addiction in therapy. Despite financial difficulties, Kevin was able to secure funding and spent several months in a live-in rehabilitation facility. During his treatment, Kevin was diagnosed with post-traumatic stress disorder (PTSD) as a result of being raped, and subsequently shared his story of sexual assault survivorship with his therapist and in group session with other members of the program. He describes feeling "like a weight was lifted" off of him because of it. While in treatment, Kevin found his extroverted nature begin to emerge once again, and recalls meeting several people in treatment that he remains close with today.

Since leaving the treatment facility, Kevin has continued to see his therapist on a regular basis. He has also undergone eye movement desensitization and reprocessing (EMDR) therapy to treat his PTSD, which he describes as being “extremely successful”. Recently, Kevin has even returned to his practical jokes- hence his pocket-sized whoopee cushion, which unsuspecting interviewers might discover the hard way.

Part Three: Discussion and References

Discussion and Conclusions

It is crucial, first, to reiterate that these narratives are not meant to replace quantitative analyses based on large samples; these interviews were conducted on an individual case study level. Thus, these narratives are not intended for generalization. Rather, this paper serves as a gentle reminder to the community of psychological research: the data studied by psychologists daily- particularly regarding trauma- comes from real people. Every data value represents an individual experience- such experiences are often lost at the aggregate level of data analysis. The anecdotal value of humanistic case studies is emotional rather than numerical- in other words, studying individual testimony grounds researchers in perceived reality rather than statistics alone.

It is also important to note the similarities between the three narratives and prior research. For example, in his interview, John described using alcohol to cope with the trauma he had experienced, which supports the findings of Luciano, Acuff, Mcdevitt-Murphy, and Murphy (2020). Similarly, Kevin described using recreational drugs in a manner not unlike John's, thus supporting the findings of Ayres (2020) regarding substance abuse as a coping strategy. In addition, Kelly and Kevin's interviews both demonstrate the concept of underreporting; research and surveying suggest that survivors of domestic and sexual abuse sometimes do not report the assault due to the nature of the crime. The trauma-response development of PTSD can be seen in all three cases (although John's has not been diagnosed), supporting the evidence that survivors of trauma have a high likelihood of developing stress or panic disorders, thus overall supporting the preliminary findings of Woodward, et. al (2019). Thus, even when utilizing a case study

approach, prior research will often remain relevant. While this study focused on individual narratives, information within these narratives can validate research findings and show common themes.

Although the coping strategies reported by the three participants supported current research, it is interesting that none of those interviewed reported utilizing a non-traditional alternative to therapy, such as meditation or yoga, as these were reported as being effective in treating PTSD and generally liked among trauma survivors. In addition, in direct contribution to prior noted research regarding veterans and trauma, John experienced no difficulty in maintaining strong relationships, as is evidenced in his relationship with his wife. This directly contradicts the research of Buchanan, Mccubbin, and Adesope (2016). Of course, one person's unique experience is not meant to be a contradiction to existing research; rather, this may be a manifestation of the limitation of case study analysis, as a group of three participants does not constitute a testable sample size, despite testability not being a focus of this paper. If testability is to be established in future studies, a much larger interviewee pool would be necessary.

At what point, however, does attempting to humanize research through case study analysis become more anonymizing than aggregate data research? When studying trauma, it is crucial to take a patient-first approach; trauma-informed interviewing and a write-up centered around confidentiality (in this case) is imperative to preserving the wellbeing of those interviewed. However, this ensured privacy means that certain details must be omitted, thus possibly altering the impact of the narrative. In addition, the small number of case studies included in this paper perhaps cause a further imbalance in privacy- fewer case studies result in a greater spotlight placed upon each. Therefore, future research devoted to rehumanizing trauma in the same fashion may yet again benefit from a larger pool of interviewees so as to remove

individual scrutiny. Interestingly, this may suggest that, in certain cases, larger sample sizes may in fact be more “humane” than smaller ones.

Despite the questions these interviews raise, this paper at minimum accomplishes one thing: elevating the voices of those who wish to tell their story. For some, sharing their experience of trauma can be a type of therapy in of itself- John found solace in sharing his story with his support group, and Kelly and Kevin both found therapy to be helpful. Kelly, John, and Kevin have each expressed that sharing their experiences furthered their healing processes, and that alone is a success. From studying individual case studies, it is possible to better understand the meaning behind quantitative trauma research, to understand real-life implications for trauma survivors, and to recognize variations in trauma experience.

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Appendix

Anonymous Survey: Paper Information Sheet

USF Honors Thesis: Case Studies in Trauma

Interviewer: McKenna Minarcin

I am asking you to take part in a case study paper that I am completing for my honors thesis.

If you choose to be in the study, you will be interviewed. This interview will help me learn more about individual experiences with trauma and coping mechanisms associated with trauma events. Your interview specifically will help me better understand your unique traumatic experience and your response. The interview will take about 2 hours to complete.

You can skip questions that you do not want to answer or stop the interview at any time. Identifying information (names, addresses, dates, etc.) will be changed or omitted, and your responses will be anonymized. I will not share identifying information with anyone.

With your consent, your responses will be included in my honors thesis, which may result in publishing or inclusion in a literary archive. Although your trauma story may be included in my thesis, any identifying information will be kept private.

Being in this case study research is optional and voluntary. Please let me know if you do not want to participate.