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Dissociation Differences Between Human-made Trauma and Natural Disaster Trauma

Heather Merrell

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Dissociation Differences Between Human-made Trauma and Natural Disaster Trauma

by

Heather Merrell

Presented to the Faculty of the
Graduate Department of Clinic Psychology
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of the requirements for the degree of
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Dissociation Differences Regarding Human-made Trauma and Natural Disaster Trauma

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Has been approved at the Graduate School of Clinical Psychology
George Fox University
As a Dissertation for the Psy.D. Degree
Approval

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Date: 12/17/2012
Contemporary psychiatric nosology defines dissociation as “a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness” (Ruiz, Poythress, Lilienfeld, & Douglas, 2008; p. 511). Dissociation as a reaction to a traumatic event remains a controversial issue. This study explored for differences in the extent and forms of dissociation, intrusion, and avoidance in human-made trauma and natural disaster trauma. A total of 232 participants were drawn from 6 samples. Natural trauma was experienced by 2 groups in Haiti (earthquake), and one in Japan (tsunami). Human trauma was experienced by samples in India (abandonment, rejection/ostracism), Southern Sudan (civil warfare), and the West Bank (war and terrorism).

In order to measure the traumas experienced and the magnitude and forms of dissociation in these populations, participants were given the Cumulative Trauma Scale (CTS) which measures the type of trauma as well as the duration of the trauma experienced; the Impact of
Dissociation Events Scale- Revised version (IES-R) which measures intrusion, avoidance factors, and hyperarousal in response to a traumatic event; and the Dissociative Experiences Scale (DES) which is a self-report measure distinguishing normal dissociation from pathological dissociation. The statistics that were used for this study included internal consistencies for the scales, descriptive statistics for each measure (means, SD), correlations among demographic measures and scales, and comparisons among the 6 samples.

Results indicated clear differences in the trauma experienced by participants who were exposed to natural and human-induced trauma. However, the impact of trauma in these groups seemed little related to whether the trauma was from natural or human causes. No significant effect was found on the IES-R total score; however, IES-R items 4, 6, 8, 10, and 21 showed significant differences between groups. Total trauma as reported on the DES-T did not differ between natural and human induced trauma, but item scores suggested a somewhat different pattern of dissociation symptoms.

Cultural differences and differences in resources, support systems, and in reporting distress may have more influence on the distress that participants reported than whether the trauma was due to human or natural causes. Other uncontrolled factors that may affect results include age, gender, socio-economic status, and education. These data raise the question of whether it will be necessary to make comparisons within a common cultural setting to further identify distinct symptomatic patterns related to whether traumas are human or nature-induced. It is also possible that the measures employed are not sensitive to differential effects of human and nature-induced trauma.
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Chapter 1

Introduction

The topic of dissociation has been a controversial topic in psychology for several years (Siegel, 2003). Dissociation is typically viewed as a disruption in the normally integrated self and has been found to be a defensive response to a traumatic event (Hulette, Kaehler, & Freyd, 2011). Much research has been done about dissociation in the western world, but not much research has been conducted internationally with dissociation (Wang, Li, Shi, Zhang, & Shen, 2010). Furthermore, researchers are looking to find the differences in dissociation across different cultures (Douglas, 2009). Kira, Fawzi, and Fawzi (2012) explain more research is needed cross-culturally in order to better understand the different or similar dynamics of different trauma types. This research proposes to examine the differences in dissociation between human-made trauma and natural disaster trauma in an international population. Data will be examined from two samples in Haiti, a sample in Southern Sudan, Japan, and West Bank.

Haiti

On January 12, 2010 Haiti experienced a devastating earthquake which struck less than 10 miles from Port-au-Prince, the capital of Haiti (Shervette, 2010). The estimated death toll of the earthquake in 2010 was 250,000 (Pierre-Pierre, 2010), but revised in 2011 by the Haitian government to 316,000 people (Satow, 2011). The Haitian government predicts that 6,000-8,000 people lost digits or limbs from the earthquake (Iezzoni & Ronan, 2010). Prior to the earthquake, Haitians with disabilities had fewer employment opportunities, lower levels of education, and
more poverty than nondisabled Haitians (Iezzoni & Ronan, 2010). A United Nations situation report on February 25, 2010 indicated 1.2 million people were in need of shelter in the aftermath of the earthquake (Iezzoni & Ronan, 2010). Nearly 24 months later, 634,000 people remained in displacement camps (Haiti, New York Times, January, 2012).

Japan

March 11, 2011, the Tohoku region of Japan was struck by the Great East Japan Earthquake. Measuring 9.0 on the Richter scale, the catastrophic quake produced a tsunami that damaged or wiped out dozens of communities in eighteen jurisdictions along the northeast coastline of Honshu, the largest of the Japanese islands (Levi, 2011). Additionally, the tsunami crippled a nuclear power station causing a nuclear disaster (Funabashi & Kitazawa, 2012). The official death toll of the Great East Japan Earthquake exceeds 15,000; 8,000+ remain missing; hundreds of thousands are now homeless or displaced; and more will inevitably die in the years to come from injury and radiation sickness (Levi, 2011).

India

Girls in India have, for many hundreds of years, been seen as an economic burden on families due to their families having to provide a dowry for daughters at the time of marriage. In addition, there is a certain elevated social status afforded to having a boy that reveals the low value placed on females in many parts of the country (Fernandes, 2007). Finally, those with handicaps are particularly likely to experience rejection.

Southern Sudan

The continuing civil war in Southern and Central Sudan has caused the deaths of about two million people since 1983, according to the United States Committee for Refugees (Roberts,
Damundu, Lomoro, & Sondorp, 2009). The United States Committee for Refugees explained that one in five of the southern Sudanese population has died from warfare, war-induced famine, or direct government or rebel policies. About 80% of southern Sudan’s estimated population of 5 million has been uprooted at one time or another since fighting began in 1983 between rebels from the animist and Christian south and forces allegiant to the government of the Arab and Islamic north (Roberts et al., 2009).

The flat, parched plains of Sudan seem to run on endlessly, right over the horizon. There are a few towns, but outside of the towns there are no roads, telephones, or electricity. The country is mostly an immense empty space of about 1 million square miles; yet Sudan is also home to roughly 28.5 million people. Because of the limited infrastructure, a person in desperate need of food or drink may find it takes days or weeks to walk to one of the dozen feeding centers run by international aid agencies (Nelan, Dowell, Mutiso, & Waller, 1998), and many die along the way.

**West Bank**

The West Bank of Palestine is currently an area of about 5,800 km squared (2.24 sq. mi). This area has been under consistent oppression, violence, uprisings, and resistance since the wars began in 1947. In the Palestinian territories more than 48,000 people were injured and hundreds of deaths occurred during the period of the Al-Aqsa Intifada (2000-2007). During the same period 7,800 homes were destroyed. From 2003-2006, about 25,000 people were displaced by the Israeli wall.

Residents of all 4 countries have been exposed to a significant amount of trauma and devastation. However, the trauma in Haiti (data from 2 occasions) and Japan resulted from
natural disaster, while the trauma in Southern Sudan, West Bank, and India is mostly the result of human acts.

**Trauma**

Creating a general definition for trauma has been a difficult task. Weathers and Keane (2007) explain that creating an all-encompassing definition of trauma has been difficult due to stressors containing different dimensions such as magnitude, frequency, complexity, duration, predictability, and controllability. Magnitude of stressors also has several meanings such as threat of harm, life threat, interpersonal loss, and property destruction. The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (*DSM-IV*) defines trauma as an “event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others” (Kira et al., 2008, p. 63). Weathers and Keane (2007) explain the following aspects of stressors are helpful for defining trauma: magnitude (threat of harm, life threat, and interpersonal loss), frequency, complexity, duration, predictability, and controllability. Kira et al. (2008) explained that The American Psychological Association Trauma Group defines a traumatic stressor as,

A process that leads to the disorganization of a core sense of self and world and leaves an indelible mark on one’s world views that psychological disorders often follow upon exposure to. Examples of such traumatic stressors included combat, rape, child abuse, life threatening accidents, and death of loved one, domestic violence, and prolonged exposure to harassment (p. 63)

Kira, et al. (2008) suggests the Trauma Group’s definition is more inclusive and not limited to just physical stressors as is the *DSM-IV*. However, unlike the *DSM-IV*, the Trauma
Group does not explicitly include personal harm or fear of personal harm in their definition. The DSM-V proposes to additionally include two symptoms for PTSD criteria which are negative expectations about the world and detachment from others (Hagennaars, Fisch, & Minnen, 2011).

**Posttraumatic Stress Disorder and Trauma.** The *DSM-IV*, (1994) defines Posttraumatic Stress Disorder as the diagnosis individuals are given who have witnessed or been directly involved in a traumatic event that involved actual or threatened death or serious injury to self or others, and the person’s response involved intense fear, helplessness, or horror. Additionally, the traumatic event is persistently re-experienced in some way such as a nightmare or flashback, the person persistently avoids the event or stimuli from the event, and the person persistently experiences symptoms of increased arousal. Weathers and Keane (2007) noted this diagnosis has served as an all-inclusive construct allowing various types of trauma such as sexual assault, combat, and natural disasters to be combined so clinicians have a general framework for how to work regarding psychological trauma and its devastating effects on a person.

Traumatic life experiences such as war, disasters, torture, and violence are known to cause severe psychological ramifications and mental disorders (Araya, Chotai, Komproe, & Jong, 2007). Kira et al. (2012) proposed the developmentally based trauma model (DBFT) which suggests responses to traumatic events will differ based upon whether the traumatic event was human or nature-induced, a one-time occurrence, a repeated occurrence in the past, or a repeated occurrence that continues in the present.

According to Christiansen and Elklit (2008), men are possibly exposed to as many as four times more traumatic experiences in their lifetime than women. However, Christiansen and Elklit (2008) proposed that women are more often exposed to highly “toxic” types of trauma
Dissociation can remain within a normal limits range such as attention lapses experienced by most people on a daily basis. However, high levels of dissociation in which a person displays...
a failure to integrate thoughts, feelings, memories, and actions into a meaningful sense of consciousness (Enriquez & Bernabeu, 2007) are seen as pathological. Dissociation has also been viewed as an adaptive response in a traumatic situation; however, it can become destructive when used in other settings (Hulette et al., 2011). Strong evidence has been found that traumatic events contribute to the development of dissociation because dissociation separates consuming mental events from consciousness (Maaranen et al., 2005). Continuing dissociative tendencies can be harmful because the individual may have difficulties recognizing interpersonal threats in the future (Hulette et al., 2011). Maaranen, et al., (2005) suggest men and women experience pathological dissociative symptoms equally, but women experience non-pathological dissociative symptoms more often than men. Though more difficult to detect and distinguish from developmentally normal functioning, children may also manifest dissociative symptoms. Research findings suggest a strong relationship between stress symptoms and dissociation (Douglas, 2009).

Men have been found to have higher frequency of amnesic dissociative experiences than women (Maaranen et al., 2005). Dissociative amnesia is a criterion for the diagnosis of PTSD; it may be that men and women respond differently to traumatic events and there may be differences in the way men and women store, consolidate, and retrieve traumatic memories (Maaranen et al., 2005).

The cause of dissociation has been studied nationally and internationally. Several studies have found that dissociation is a consequence of trauma (e.g., Rassin & Rootselaar, 2005). Betrayal Trauma Theory proposes that dissociation is most likely to occur when a trauma is perpetrated by someone with whom the victim has a close relationship (Hulette et al., 2011).
Adults who reported experiencing some form of sexual abuse as children also reported higher levels of dissociation in adulthood (Rassin & Rootselaar, 2005). Children who experience multiple forms of maltreatment are also likely to have high levels of dissociation (Hulette et al., 2011).

Some research has been conducted on the correlation of human-made trauma and dissociation in the Western World, however not much research has been conducted on natural and human trauma trauma in the non-Western World in relation to dissociative symptoms (Wang et al., 2010). One study used a sample of Chinese participants who experienced the earthquake on China in 2008 (Wang et al., 2010). It found that the participants reported dissociation in reaction to the earthquake they experienced (Wang et al., 2010). Another study conducted on earthquakes in Greece found that the survivors of the earthquakes experienced higher levels of depression, anxiety, and PTSD (Madianos & Evi 2010).

**Dissociative Identity Disorder.** Dissociation is typically a key feature in specific diagnostic groups such as dissociative disorders, posttraumatic stress disorder, and personality disorders (Maaranen et al., 2005). Connections between high levels of dissociation and eating disorders, substance abuse, anxiety and mood disorders have also been found (Maaranen et al., 2005). Dissociation is a symptom of the disorder known as Dissociative Identity Disorder (DID). The *DSM-IV* (1994) identifies the essential features of DID as the presence of two or more distinct identities or personalities that recurrently take control of a person’s behavior. Patients diagnosed with DID typically experience major disruptions in their normal integrative functions of memory, consciousness, identity, self, and world (Rodewald, Dell, Wilhelm-Gobling, & Gast, 2011).
The purpose of this study is to compare and contrast the dissociation experienced by individuals involved in human-made trauma and natural disaster trauma. The international traumatic events in this study will be the natural trauma experienced by two groups in Haiti (earthquake), and one in Japan (tsunami), and the human trauma experienced by samples in India (abandonment, rejection/ostracism), Southern Sudan (civil warfare), and the West Bank (war and terrorism).

Based on Hulette et al. (2011), it is hypothesized that there will be more dissociation in those who experienced human-made trauma. In addition, the forms of dissociative experience will be examined to explore for any association between the type of trauma and specific pattern of dissociative responses. This study is relevant because it will provide further research on the topic of dissociation in relation to trauma. It will additionally provide further information that may aid relief workers to implement effective psychological assistance to those who are suffering from different forms of traumatic experience.
Chapter 2

Methods

Participants

This study will employ archival data collected by Dr. George Rhoades. A total of 232 participants were drawn from six samples. Natural trauma was experienced by two groups in Haiti (earthquake), and one in Japan (tsunami). Human trauma was experienced by samples in India (abandonment, rejection/ostracism), Southern Sudan (civil warfare), and the West Bank (war and terrorism). Each of the samples included males and females ranging from 14-65 years old. The education level for the participants ranged from 3 years of education to a college level education. Descriptive data were missing for the first Haiti group. The second group of Haiti participants were 25 (36%) male and 44 (64%) female participants ranging from 14-65 years old with a mean age of 29.4 (SD = 9.3) and at least 3 years of education. Japan’s participants were 5 (42%) male and 7 (58%) female ranging from 19-50 years old with a mean age of 29.4 (SD = 11.5) and a minimum of 4 years of education. India’s participants were 7 (27%) males and 19 (73%) females who ranged from 22-62 years old with a mean age of 39.2 years (SD = 13.4) and a minimum of 4 years of education. Southern Sudan’s participants were 22 (71%) male and 9 (29%) female, 14-65 years old with a mean age of 36.8 years (SD = 10.8), and a minimum of 3 years education. Finally, West Bank’s participants were 11 (48%) male and 12 (552%) female ranging from 21-72 years old with a mean age of 34.9 years (SD = 12.2) and a notable difference in education, a minimum of 12 years.
Instruments

The instruments used in this study include a demographic questionnaire, Cumulative Trauma Scale, Impact of Event Scale-Revised, and Dissociative Experiences Scale. Each will be described in turn. Demographic questions included age, gender, and years of education.

**Cumulative Trauma Scale.** The Cumulative Trauma Scale (CTS) includes 22 items that measure the kinds of traumatic events experienced and their recurrence over the respondent’s lifetime (e.g., torture, war, discrimination, rape, sexual and physical abuse, car accidents, abandonment by parents, or natural disasters). The measure is a short form of a more elaborate measure and is based on the taxonomy of trauma developed by Kira et al. (2008). Item responses are in a Yes/No format.

Kira et al. (2008) reported an alpha reliability coefficient for the scale of .85. Exploratory factor analysis found that six factors accounted for 58.73% of the variance: collective identity trauma (e.g., “discriminated against or threatened due to race or ethnicity or religion”), family trauma (e.g., divorce and family history of violence), secondary traumatization or interdependence trauma (e.g., witnessing killing of others), personal identity/autonomy trauma (e.g., sexual abuse), survival trauma (e.g., natural or human-made disaster), and attachment trauma. Confirmatory factor analysis found good fit for the first five factors, at.95. Kira developed subscales based on these results. The CTS was found to have good concurrent validity; it correlated significantly with PTSD and cumulative trauma disorder (CTD) scales (Kira et al., 2008). Alpha in the present sample was 0.80 for the CTS.

**Impact of Event Scale-Revised (IES-R).** The Impact of Event Scale was designed in 1979 as a subjective measure of intrusion and avoidance immediately following trauma...
Dissociation (Horowitz et al, 1979). It is based on Horowitz’s hypothesis, which indicates that the emotional path following a traumatic event is comprised of two alternating and opposing experiences: intrusion and avoidance (Horowitz et al, 1979). Intrusion is comprised of “nightmares, unbidden visual images and intrusive thoughts about the traumatic event, “whereas avoidance entails ‘deliberate efforts not to think [and/or talk about it, as well as to] avoid reminders of the event’” (Weiss, 2007). The scale consists of 66 yes or no statements divided into two sub-categories differentiating intrusion or avoidance factors. The IES was not created to be a measure of PTSD as PTSD was not yet included in the DSM. However, once PTSD was incorporated as a diagnostic disorder, the IES began to be utilized as a measure of post-traumatic syndrome.

While both intrusion and avoidance are aspects of PTSD symptomology, they are not alone. The DSM defined the third dimension of PTSD as physiological hyperarousal. In order to complement this symptom triad, the IES-Revised was created (IES-R, Weiss & Marmar, 1997). The IES-R consists of eight items each measuring both intrusion and avoidance. Added to intrusion and avoidance are six items measuring physiological hyperarousal. In contrast to the IES, the IES-R utilizes a five-point Likert scale as a measure of distress, with a response range of 0 not at all to 4 extremely. (www.ptsd.va.gov). The IES-R has also been shown to have good psychometric properties (Brunet, St-Hilaire, Jehel, & King, 2003). Alpha in the present sample was 0.88.

**Dissociative Experiences Scale.** The Dissociative Experiences Scale (DES) was developed by Bernstein and Putnam (1986) and is composed of 28 self-report items that measure a variety of dissociative symptoms. The scale helps to discriminate between high and low levels of dissociation and can assess dissociation within normal limits (experienced daily by most
individuals including attention lapses), as well as at pathological levels (failure to integrate thoughts, feelings, memories, and actions into a meaningful sense of consciousness). Item reading levels range from 6th to 13th grade. The scale takes approximately ten minutes to complete and asks the participant to score items on a continuum ranging from 0 to 100. Higher values suggest an increased frequency of dissociative experiences. Values above 30 are believed to indicate potential dissociative psychopathology. For the purposes of this study only the 8 DES taxon items were given, which will limit this study to those eight items.

Wright and Loftus (1999) found in several studies the DES yielded high internal reliabilities (above .90 on Cronbach’s alpha). Leavitt (1999) also found the DES to produce good test-retest reliability (.84-.96).

The convergent validity was very good for the DES. Van Ijzendoorn and Schuengel (1996) found the DES correlated well with similar questionnaires: the Perceptual Alteration Scale (PAS), Tellegen Absorption Scale (TAS), The Questionnaire of Experiences of Dissociation (QED), as well as with some measures based on interviews, including the Structured Clinical Interview for Dissociative Disorders (SCID-D) and the Dissociative Disorders Interview Schedule (DDIS). The overall combined correlation across various measures was \( r = .67 \), and the overall mean Cohen’s \( d \) was \( d = 1.82 \). One study used the DES with a Spanish psychotic population to determine if the patients experienced dissociation and found that generally the patients who experienced more severe traumatic childhood experiences reported more auditory hallucinations (Perona-Garcelan, et al., 2010). In the present sample, internal consistency alpha was 0.91.
Procedure

Participants from Haiti, Sudan, Japan, and the West Bank who had survived completed a series of surveys that included the demographic questionnaire; the 20-item Cumulative Trauma Scale (CTS); the Impact of Events Scale-Revised version (IES-R); and the 8-item Taxon version of the Dissociative Experiences Scale (DES-T). The only exception to this procedure was that the sample from Japan did not fill out the IES-R. The demographic questionnaire assessed for age, gender, and years of education. The CTS assessed for the type of trauma the participant has experienced or witnessed and the IES-R assessed for intrusion, avoidance, and hyperarousal. Finally, the DES-T measured dissociative experiences during and after the traumatic event.

Data Analysis

The independent variable for this study was the type of trauma to which each participant was exposed, either human-made (Southern Sudan, West Bank, India) or natural disaster (Haiti and Japan). The dependent variables were the variation (similar degrees, similar kinds) in dissociative experiences (DES-T) and the degree of intrusion and avoidance (IES-R) that participants reported. The statistics that were used for this study include internal consistencies for the scales, descriptive statistics for each measure (means, SD) correlations among demographic measures and scales, and comparisons of participants exposed to human and naturally caused traumas.
Chapter 3

Results

A significant effect was found on the CTS ($F_{1, 143} = 58.10; p < .001$) that indicated that participants reported different amounts of trauma when exposed to natural and human caused traumas. Eighteen of the twenty CTS items showed significant effects. Scores associated with human trauma were higher as a result for sixteen of these items. Human-caused traumas were associated with a significantly higher total score on the CTS; the Cohen’s $d$ of 1.26 is considered large (see Table 1). In the present sample, internal consistency alpha was 0.80.

Table 1

*Means, Standard Deviations, and Group Differences on Cumulative Trauma Scale*

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>DF</th>
<th>F</th>
<th>P</th>
<th>Cohen’s $d$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human-Induced Traumas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>27.3</td>
<td>3.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudan</td>
<td>32.2</td>
<td>3.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Bank</td>
<td>28.1</td>
<td>3.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>29.1</td>
<td>4.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural Traumas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haiti A</td>
<td>24.7</td>
<td>1.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haiti B</td>
<td>25.6</td>
<td>1.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>24.1</td>
<td>2.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25.0</td>
<td>2.1</td>
<td>1,143</td>
<td>58.1</td>
<td>&lt;.001</td>
<td>1.26</td>
</tr>
</tbody>
</table>
No significant difference was found on the IES-R total score, which sought to measure the extent of reported trauma ($F_{(1, 151)} = 0.42; NS$). However, IES-R items 4, 6, 8, 10, and 21 showed significant differences between groups; for two of these, human trauma was associated with higher scores and for three natural traumas was associated with higher scores. In the present sample, internal consistency alpha was 0.88. See Table 2.

Table 2

<table>
<thead>
<tr>
<th>Means, Standard Deviations, and Group Differences on Impact of Events- Revised Scale</th>
<th>Mean</th>
<th>SD</th>
<th>DF</th>
<th>F</th>
<th>P</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human-Induced Traumas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>33.8</td>
<td>17.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudan</td>
<td>49.4</td>
<td>12.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Bank</td>
<td>27.1</td>
<td>22.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>36.4</td>
<td>19.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural Traumas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haiti A</td>
<td>41.1</td>
<td>18.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haiti B</td>
<td>44.6</td>
<td>16.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>38.4</td>
<td>17.0</td>
<td>1, 151</td>
<td>.42</td>
<td>NS</td>
<td></td>
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</tbody>
</table>

No differences were found related to the nature of trauma experienced for the sum of the DES-T items ($F_{(1, 163)} = 0.34; NS$). However, four of eight DES-T items showed significant differences. Scores on DES-8 were higher for those exposed to human trauma ($F_{(1, 210)} = 4.15; p = .043$), while scores on DES-12, DES-13, and DES-27 were higher for those exposed to natural
traumas \( F_{(1, 217)} = 10.80; p < .001; F_{(1, 214)} = 6.07; p = .015; F_{1, 212} = 10.83; p < .001 \) respectively). Moderate effect sizes were found for these four items. In the present sample, internal consistency alpha was 0.91. See Tables 3 and 4.

Table 3

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>DF</th>
<th>F</th>
<th>P</th>
<th>Cohen’s d</th>
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<tr>
<td><strong>Human-Induced Traumas</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>India</td>
<td>132.7</td>
<td>106.3</td>
<td></td>
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<tr>
<td>Sudan</td>
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<td>112.1</td>
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<td>West Bank</td>
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<td>122.7</td>
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<td>114.8</td>
<td>117.5</td>
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<tr>
<td><strong>Natural Traumas</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Haiti A</td>
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<tr>
<td>Haiti B</td>
<td>25.6</td>
<td>1.9</td>
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<tr>
<td>Japan</td>
<td>12.7</td>
<td>11.0</td>
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<td><strong>Total</strong></td>
<td>126.5</td>
<td>135.0</td>
<td>1,163</td>
<td>.34</td>
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</tr>
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</table>
Table 4

Means, Standard Deviations, and Group Differences on Dissociative Experiences Taxon Scale

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>DF</th>
<th>F</th>
<th>P</th>
<th>Cohen’s d</th>
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<tbody>
<tr>
<td>DES 3</td>
<td></td>
<td></td>
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<tr>
<td>Natural Trauma</td>
<td>13.6</td>
<td>23.2</td>
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<tr>
<td>Human Trauma</td>
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<td>19.4</td>
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<tr>
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<td>18.1</td>
<td>1,215</td>
<td>.9</td>
<td>NS</td>
<td></td>
</tr>
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<td>DES 7</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
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<td>8.4</td>
<td>18.4</td>
<td></td>
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<tr>
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<td>12.8</td>
<td>24.1</td>
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<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10.1</td>
<td>20.8</td>
<td>1,213</td>
<td>2.2</td>
<td>NS</td>
<td></td>
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<tr>
<td>DES 8</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>17.5</td>
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<td>21.1</td>
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<tr>
<td><strong>Total</strong></td>
<td>9.7</td>
<td>19.1</td>
<td>1,210</td>
<td>4.2</td>
<td>.04</td>
<td>-0.28</td>
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<td>DES 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>29.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>9.6</td>
<td>16.8</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17.2</td>
<td>26.3</td>
<td>1,217</td>
<td>10.8</td>
<td>&lt;.001</td>
<td>0.49</td>
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<td>24.3</td>
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<td>21.3</td>
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<tr>
<td><strong>Total</strong></td>
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<td>23.5</td>
<td>1,214</td>
<td>6.1</td>
<td>.02</td>
<td>0.35</td>
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<td><strong>Total</strong></td>
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<td>29.4</td>
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<tr>
<td>DES 27</td>
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<tr>
<td>Natural Trauma</td>
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<tr>
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<td>26.8</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td>27.5</td>
<td>30.2</td>
<td>1,212</td>
<td>10.8</td>
<td>&lt;.001</td>
<td>0.47</td>
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</table>
Chapter 4
Discussion

The results indicated that significant differences were found between groups in terms of kinds and amounts of trauma that participants reported. Participants who had experienced human trauma reported higher levels of trauma at both item and scale levels on the CTS than participants who experienced nature caused traumas.

Item 12 (I experienced the sudden death of a loved one or close friend) and item 20 (I witnessed/experienced the accidental killing of another person) on the CTS did not display significant difference between the two groups’ responses. Participants who experienced nature caused traumas reported higher levels on item 9 (I witnessed or experienced a natural disaster) and item 13 (I have seen dead bodies, other than at a funeral) than participants who experienced human made traumas. However, participants who experienced human made trauma reported higher levels on the remaining 16 items such as: item 1) I lived in a country that was at war with another country, item 11) I was tortured by another person, and item 19) I witnessed/experienced the intentional killing of another person. The probability of a type 1 error (false positive) occurring on these items was about 0.01 meaning there is a 1% chance that participants who reported experiencing human traumas did not report higher levels of trauma on these items.

No differences in the overall impact of trauma were found on the IES-R. However, there were significant differences reported in the specific forms of impact between the two groups on 5 items. For example, human trauma participants reported higher levels of feeling irritable (item 4). In contrast, nature trauma participants rated elevated levels on item 6 (I thought about it when I didn’t mean to), item 8 (I stayed away
from reminders about it), item 10 (I was jumpy and easily startled), and item 21 (I felt watchful and on guard). The probability that a type 1 error occurred on these items was about 5%.

As noted above, many studies have found that dissociation is a consequence of trauma (e.g., Rassin & Rootselaar, 2005). Additionally, Kira et al. (2012) explain the stress sensitization hypothesis which suggests that repeated trauma exposure increases the likelihood of a pathological response, including dissociation. Thus it is surprising that our participants who were exposed to human-induced trauma reported a greater degree of traumatization, but did not report higher levels of intrusion, avoidance, or hyperarousal on the Impact of Events Scale.

In this study, total trauma as reported on the DES-T also did not differ between natural and human induced trauma. Again it is somewhat surprising that we did not find higher levels of dissociation among those exposed to human trauma despite their reports of a higher degree of traumatization. These findings do not support the Betrayal Trauma Theory, which proposes dissociation is most likely to occur when a trauma is perpetrated by someone with whom the victim has a close relationship (Hulette et al., 2011). Perhaps the nature of the trauma, associated with civil war (Southern Sudan) or terrorism (West Bank) accounts for this as these traumas may have been caused by persons who were unknown to their victims. Betrayal may be less significant with such traumas than in situations where the perpetrator is known and previously thought to be “safe.” Item scores, however, suggested a somewhat different pattern of dissociation symptoms depending on the kind of trauma experienced.

Participants in the Haiti A group endorsed greater amounts of dissociation than the other natural trauma groups. One reason for this discrepancy may be because this group had more participants than the other natural trauma groups. Another reason may be that the Haiti A data were gathered soon after the trauma whereas Haiti B data were gathered several months after the trauma, thus allowing participants more time to adjust and not display as many symptoms of dissociation. Finally, perhaps Haiti A and Japan differed significantly due to Japanese participants having an overall higher average of years of education and more economic stability.
compared to Haiti A, making it more likely Japan participants had the cognitive skills and other resources to cope better than most participants in Haiti A. Items 8, 12, 13, and 27 differed significantly between the groups’ responses.

Natural trauma participants scored higher on item 12 (Some people have the experience of feeling that other people, objects, and the world around them are not real) 13 (Some people have the experience of feeling that their body does not seem to belong to them), and 27 (Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing). Human trauma participants endorsed higher levels on item 8 (Some people are told that they sometimes do not recognize friends or family members). This suggests there are subtle differences in the way participants’ experience dissociation depending on the type of trauma they experienced. Such differences could affect the therapy process of such individuals. Overall the likelihood that a type 1 error occurred on these scales and the DES-T items is moderate to small.

Although participants exposed to human-caused trauma reported higher levels of trauma, the overall impact of trauma in these groups seemed little related to whether the trauma was from natural or human causes, as illustrated by similar total scores for both the impact of trauma and the degree of dissociation. However, clear differences were reported in the specific sorts of trauma experienced by the two groups. Item differences on the IES-R and DES-T suggests some subtle differences in the specific effects of natural and human induced trauma on intrusion, avoidance, and dissociative responses of participants. For instance human trauma was associated with higher levels on one question on the IES-R assessing for hyperarousal (item 4). Natural trauma participants endorsed elevated scores on 4 items; one measuring intrusion (item 6), one measuring avoidance (item 8), and 2 items measuring hyperarousal (items 10 and 21).

In the present study we did not control for age, gender, socio-economic status, or education of the participants. Future studies would likely benefit by employing controls for these variables. We wonder whether control for these factors might change the results.
Perhaps cultural differences and differences in resources, education, support systems, and in disposition toward reporting distress may have more influence on the distress that participants reported. Kira et al. (2012) explain the developmentally based trauma model (DBFT), which integrates the three main paradigms of traumatic stressors; the psychiatric paradigm, the psychoanalytic and developmental paradigm, and the intergroup paradigm, in order to better understand the etiology of mental illnesses in response to trauma. These findings do not provide support for the first element of Kira et al.’s model: these data provide no evidence of different responses to human- and nature-induced traumas. Kira et al. (2012) propose more studies are needed to identify the different or similar dynamics of different trauma types in different populations and cultures to perfect this model. These data along with existing literature raise the question of whether it will be necessary to make comparisons within a common cultural setting to further identify distinct symptomatic patterns related to whether traumas are human or nature-induced. Alternatively better demographic data, such as for education and income, and controlling for these variables may make findings more sensitive to differences in the sources of trauma.
References


Şar, V. (2008) Trauma and dissociation in context: personal life, social process, and public health. *Journal of Trauma & Dissociation, 9*(1), 1-8. DOI: 10.1080/15299730802073601


Appendix A

Cumulative Trauma Survey
George F. Rhoades, Jr., Ph.D. (2008)
Instructions: The following is a list of stressful life events that can occur during a natural (i.e. earthquake, tsunami) or manmade (i.e. terrorism, war) disaster. Please read each item, and then indicate if you have experienced this event by circling the yes or no next to the item.

1. I lived in a country that was at war with another country. Yes No
2. I lived in a country that was in a civil war. Yes No
3. I witnessed another person being physically assaulted. Yes No
4. I was physically assaulted by another person. Yes No
5. I witnessed another person being sexually assaulted. Yes No
6. I was sexually assaulted. Yes No
7. I lived in a country that experienced terrorism. Yes No
8. I personally survived a terrorist attack. Yes No
9. I witnessed or experienced a natural disaster. Yes No
10. I witnessed another person being tortured. Yes No
11. I was tortured by another person. Yes No
12. I experienced the sudden death of a loved one or close friend. Yes No
13. I have seen dead bodies, other than at a funeral. Yes No
14. I have experienced a life threatening medical illness. Yes No
15. I was forced into servitude or slavery. Yes No
16. I was kidnapped. Yes No
17. I was involved in combat. Yes No
18. I experienced a life threatening accident. Yes No
19. I witnessed/experienced the intentional killing of another person Yes No
20. I witnessed/experienced the accidental killing of another person Yes No
21. [please write in another traumatic event not listed, but that you also witnessed or experienced] _____________________________________________________________________
Appendix B

Impact of Event Scale-Revised
**Instructions:** The following is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you *during the past 7 days* with respect to the _________. How much were you distressed or bothered by these difficulties?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderate-ly</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Any reminder brought back feelings about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>I had trouble staying asleep.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Other things kept making me think about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>I felt irritable and angry.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>I avoided letting myself get upset when I thought about it or was reminded of it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>I thought about it when I didn’t mean to.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>I felt as if it hadn’t happened or wasn’t real.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>I stayed away from reminders about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>Pictures about it popped into my mind.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>I was jumpy and easily startled.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>I tried not to think about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>I was aware that I still had a lot of feelings about it, but I didn’t deal with them.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix C

Curriculum Vitae
Heather Merrell, M.A.
9385 SW Maplewood Dr. Apt. O162
Tigard, OR 97223
Phone: 513-382-0879
Email: hmerrell09@georgefox.edu

Education

(Anticipated Graduation: April 2014)  
**Doctoral Student of Clinical Psychology Program**  
Graduate School of Clinical Psychology, APA Accredited  
George Fox University, Newberg, Oregon

(December 2011)  
**Master of Arts, Clinical Psychology**  
Graduate School of Clinical Psychology, APA Accredited  
George Fox University, Newberg, OR

(May 2009)  
**Bachelor of Arts, Psychology**  
Cedarville University, Cedarville, OH

Honors and Awards

(2008-2009)  
Cedarville University Dean’s List

Professional Affiliations

(2009 – Present)  
American Psychological Association, Graduate Student Affiliate

Supervised Clinical Experience

(August 2012- Present)  
**George Fox University Health and Counseling Center, Practicum III-Newberg, OR**  
Position: Practicum Student  
Setting: University Counseling Center  
Population: Traditional and non-traditional undergraduate and graduate students  
Duties: Provided intake assessments, LD assessments, consultation, diagnosis, treatment planning, and solution-focused individual psychotherapy to undergraduate and graduate students; received weekly individual and group supervision from licensed psychologists; wrote progress notes; dictated intake sessions; taped several individual sessions and reviewed them during individual supervision; provided supervision to a second year doctoral student for one month in order to help the student transition into a practicum setting and conceptualize and treatment plan with clients; consulted with peer...
practicum students and research in order to better conceptualize and provide the most effective intervention for clients.

(September 2011- June 2012)  **Rural School District Consortium, Practicum II -Yamhill, OR**
Position: Practicum student at the Student Based Mental Health Clinic
Setting: Yamhill Carlton School District
Population: Rural intermediate and high school students
Supervisors: Gene Bundy, LCSW; Elizabeth Hamilton, Ph.D.
Duties: Provided individual and group psychotherapy to adolescents; conducted assessments for adolescents and attended Individualized Educational Plan (IEP) meetings in order to present and interpret the results for the student, parents, teachers, and principle in order to advocate for appropriate accommodations; provided treatment planning; wrote progress notes and comprehensive assessment reports; consulted with peers and received weekly group supervision provided by a licensed clinical social worker and received individual supervision provided by a licensed psychologist.

(August 2010- August 2011)  **Chehalem Youth and Family Services, Practicum I- Newberg, OR**
Position: Practicum student
Setting: Community Mental Health
Population: Low-income individuals and residential adolescents
Supervisors: Austin Burres, M.A.; Karen Hernandez, Ph.D.
Duties: Provided intake assessments, diagnosis, treatment planning, and individual psychotherapy for community members with a broad spectrum of psychological disorders; co-led group counseling for residential adolescents; received weekly individual and group supervision from a doctoral intern student as well as a licensed psychologist; wrote intake reports and progress notes.

(January 2010-April 2010)  **George Fox University, Pre-practicum II -Newberg, OR**
Position: Pre-practicum student
Setting: University
Population: One traditional male and female undergraduate student
Supervisors: Rachael Kerns, M.A.; Mary Peterson, Ph.D.
Duties: Provided simulated psychotherapy to one female and one male undergraduate student; provided intake interviews, diagnosis, and treatment planning; wrote intake reports and progress notes; performed case presentations and consultation with both supervisor and clinical teams; received weekly individual and group supervision which included tape review of sessions.

(September 2009- December 2009)  **George Fox University, Pre-practicum I-Newberg, OR**
Position: Pre-practicum student
Setting: University
Population: Peer graduate students
Supervisors: Rachael Kerns, M.A.; Mary Peterson, Ph.D.
Duties: Provided individual simulated psychotherapy for peer graduate students; received weekly individual and group supervision which included tape review of sessions.

**Research Experience**

(February 2010-Present)  **Graduate Department of Clinical Psychology-Newberg, OR**
Position: Research Vertical Team Member
Supervisor: Rodger Bufford, Ph.D.
Responsibilities: Participate in biweekly meetings to discuss a variety of research projects, including each of the members’ dissertations. Present own dissertation research and progress, collaborate on group research projects, and generate future research ideas.

**Graduate Research:**
*(2010-Present)*

**Doctoral Dissertation**

*International Dissociation Differences between Human-Made and Nature-Made Trauma*

George Fox University, Newberg, OR
Dissertation Chair: Rodger Bufford, Ph.D.
Committee Members: Kathleen Gathercoal, Ph.D. & Winston Seegobin, Psy.D.

*(April 2012)*

**Consultation Project**

*Willamette Family Medical Center Integrated Behavioral Health Resource Handbook*

Lilia Luna, M.A.; Michelle Mckinley, M.A.; Heather Merrell, M.A.; & Heather Paige, M.A.

**Poster Presentations:**
*(August 2013)*

**Doctoral Dissertation**

*International Dissociation Differences between Human-Made and Nature-Made Trauma*

Presented at American Psychological Association Annual Convention; Honolulu, HI
Heather Merrell, M.A.; Rodger Bufford, Ph.D.; Kathleen Gathercoal, Ph.D. & Winston Seegobin, Psy.D.

*(June 2012)*

**Students against Bullying**

Presented at Providence Kid’s Day Health Fair; Portland, OR

*(August 2012)*

**Safe Dates: A Pilot Study in a Rural School District Setting**

Presented at Contemporary Families 2012: Building Blocks to a Better Practice; Portland, OR
Carolyn Lawry, M.A.; Heather Merrell, M.A.; & Elizabeth Hamilton, Ph.D.

*(April 2011)*

**Impact of Civil War: Trauma in Southern Sudan**

Presented at Western Psychological Association Convention; Los Angeles, CA
Authors: George Rhoades, Ph.D.; TuJuana Wade, B.A.; Heather Merrell, B.A.; Chad Houchin, M.A., & Rusty Smith, M.A.
Supervisor: Rodger Bufford, Ph.D.

*(April 2011)*

**Impact of Natural Trauma Haiti’s 2010 Earthquake**; Los Angeles, CA
Authors: Kristie Knows-His-Gun, M.A.; TuJuana Wade, M.A.; Heather Merrell, B.A.; & George Rhoades, Ph.D.
Supervisor: Rodger Bufford, Ph.D.

**Undergraduate Senior Research:**
*(September 2008-May 2009)*

**An Examination of Underlying Prejudice toward Homosexual Couples**

Cedarville University, Cedarville, OH
Supervisor: Amanda Burger, M.A.
Teaching Experience

(August 2012-Present)  Position: Teaching Assistant
Supervisor: Kristina Kays, Psy.D.
Population: Undergraduate students enrolled in PSYC 382 (Advanced Counseling)
Duties: Facilitated a group of undergraduate students once a week discussing course curriculum as well as providing 2 tape reviews of mock counseling sessions.

(September 2012-Present)  Position: Oversight/Mentor
Supervisor: Joel Gregor, Psy.D.
Duties: Provide oversight for a 2nd year student in the doctoral clinical psychology program at GFU for 30 minutes every week.

Relevant Volunteer Experience

(September 2009, 2011)  Juliete’s House, McMinnville, OR
Duties: Spent a day serving the Child Abuse Assessment Center with fellow Psy.D. graduate students by completing labor tasks such as managing mail duties, gardening, and painting the facility.

(September 2008- May 2009)  Miami Valley Women’s Center, Cedarville, OH
Position: Student Volunteer
Duties: Provided intakes and administered pregnancy tests; provided results of the pregnancy tests and helped women find resources within the community.

Assessment Experience: Administered, Scored, and Interpreted

- Wechsler Adult Intelligence Scale-IV (WAIS-IV)
- Wechsler Intelligence Scale for Children-IV (WISC-IV)
- Wide Range Achievement Test-IV (WRAT-IV)
- Wide Range Intelligence Test (WRIT)
- Peabody Picture Vocabulary Test-IV (PPVT-IV)
- Wide Range Assessment of Memory and Learning-II (WRAML-II)
- Wechsler Individual Achievement Test-III (WIAT-III)
- 16PF 5th Edition
- Millon Clinical Multiaxial Inventory-III (MCMI-III)
- Minnesota Multiphasic Personality Inventory-II (MMPI-II)
- Personality Assessment Inventory (PAI)
- Behavior Rating Inventory of Executive Functioning- Adult and Self Report Version (BRIEF-A, BRIEF-SR)
- Millon Adolescent Clinical Inventory (MACI)
- Behavior Assessment System for Children, Second Edition (BASC-2)
- Rorschach
- House -Tree -Person (HTP)
• Thematic Apperception Test (TAT)
• Woodcock Johnson Test of Cognitive Abilities-III (WJ-III)
• Woodcock Johnson Test of Achievement -III (WJ-III)
• Trauma Symptom Checklist for Children (TSCC)
• DKEFS-20 questions
• DKEFS-Sorting
• DKEFS-Trail Making
• Grip Strength
• Grooved Pegboard
• Wisconsin Card Sorting Test (WCST)
• Tactual Performance Test
• Test of Memory Malingering (TOMM)
• Trail Making Test
• Reitan-Klove Sensory Perceptual Evaluation
• Repeatable Battery for Assessment of Neuropsych. Status (RBANS)
• Rey-Osterrieth Complex Figure
• Seashore Rhythm Test
• Speech Sounds Perception Test
• Boston Naming Test
• California Verbal Learning Test-2
• Controlled Oral Word Association

Professional Development

- October 2012 Treating Gender Variant Clients
  Erica Tan, Psy.D.
- March 2012 Mindfulness and Christian Integration
  Erica Tan, Psy.D.
- November 2011 Cross-Cultural Psychological Assessment
  Tedd Judd, Ph.D.
- October 2011 Motivational Interviewing & A Work in Progress
  Michael Fulop, Psy.D.
- June 2011 Assessment of ADHD in Children and Adults
  Steven J. Hughes, Ph.D., LP, ABPDN
- March 2011 Neurobiological effects of Trauma
  Anna Berardi, Ph.D.
- February 2011 Best Practices in Working with Gay, Lesbian, and Bisexual Clients
  Jennifer Bearse, M.A.
- October 2010 Best practices in Multi-cultural assessment
  Eleanor Gil-Kashiwabara, Ph.D.
- October 2010 Primary Care Behavioral Health: Where Body, Mind (& Spirit) Meet
  Neftali Serrano, Ph.D.
- March 2010 Current Guidelines For Working With Gay, Lesbian, and Bisexual Clients; The new APA practice guidelines
  Carol Carver, Ph.D.
February 2010
Integrative and Clinical Dimensions of Gratitude
Phil Watkins, Ph.D.

References

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