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Relative Impact of Human & Natural Trauma on Psychological Functioning

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Relative Impact of Human & Natural Trauma on Psychological Functioning

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Abstract

Trauma, both natural and human induced, affects numerous people daily, often significantly impairing their quality of life. Human trauma and the subsequent quality of life has been extensively examined, but natural trauma remains largely overlooked. This study compares the quality of life following human and natural trauma. Because no suitable measure could be located, a 12-item Natural Disaster Assessment (NDA) was developed. Reponses were rated on a 7-point continuum from *strongly agree* to *strongly disagree*. Participants were recruited using Mechanical Turk. Among 136 participants, 56 were male (41.2%), 79 were female (58.1%), and one identified as other (0.7%). Participants completed a demographic questionnaire, Adverse Childhood Experiences (ACEs; Felitti, et al., 1998), Cumulative Trauma Scale (CTS; Kira et al., 2008), Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al, 1988, 1990), NDA, Impact of Events Scale-Revised (IES-R; Weiss & Marmar, 1997), International Trauma Questionnaire (ITQ; part A and part B Cloitre, et al., 2018), and the Satisfaction with Life Scale (SWLS; Pavot & Diener, 1993). Alpha for the NDA was .83; mean and standard deviation were 33.28/3.13. Results suggested social support was unrelated to NDA but negatively correlated with ACEs (r = -.41). NDA was unrelated to satisfaction with life, but was strongly negatively related to the CTS and negatively related to IES-R, ITQ-A, and ITQ-B. In contrast, ACEs also had no relationship to satisfaction with life, a significant negative correlation with social support, and significant positive correlations with IES-R, ITQ-A, and ITQ-B. Results clearly differ for natural and human trauma. It appears human trauma may accompany natural trauma and divert attention from natural trauma or alter its impact. Limitations include participants who may or may not have experienced a trauma. Future studies should confirm the presence of trauma to better compare human and natural trauma.

Keywords: trauma, social support, quality of life, natura trauma, human trauma

Table of Contents

List of Tables

Chapter 1

Trauma impacts numerous people daily. About 70% of American adults have experienced some form of a traumatic event at least once in their lifetime (MindWise, 2019). Trauma can come in the form of natural disasters or by human causes. Human-caused traumas are caused by human design or human failure. Human trauma can include but is not limited to war, rape, abuse, and torture (EBSCOhost, n.d.). Natural traumatic experiences are often known as an "act of God." Natural trauma includes, but is not limited to, earthquakes, hurricanes, tornadoes, and wildfires (EBSCOhost, n.d.). Natural disasters are typically considered traumatic and can produce physical and mental effects. The amount and intensity of exposure to a disaster is a significant risk factor for acquiring post-disaster post-traumatic stress disorder (PTSD). More intense and longer lasting mental health outcomes are often associated with events that include witnessing death or injury of others, property loss, physical injury, and threat to life (Harville et al., 2015). Many studies have looked at trauma and the quality of life after trauma, but few have compared the quality of life following human and natural trauma. Quality of life is defined as the extent to which an individual is comfortable, healthy, and able to engage in or enjoy life events. It encompasses various domains such as emotional, physical, mental, and social functioning (Croft & Byrd, 2020).

Merrell et al. (2013) analyzed dissociation following natural and human trauma among an international population. They compared the dissociation experienced by individuals involved in natural and human trauma. Results suggested little variation in the trauma involved by participants who were exposed to human and natural trauma. One limitation to this study is that they did not control for gender, age, socio-economic status, or education of the participants. In

addition, natural trauma was assessed by a single item, and natural and human trauma were assessed in different cultural settings and time periods.

Smith et al. (2014) examined the vicarious psychological experience of the Haiti earthquake among Haitians living in the United States and the relationships between their use of coping resources and trauma symptoms. Coping resources consisted of family, religious, and community support. Results indicated that women reported significantly more severe symptoms than men ($F_{1, 420} = 7.64$, $p = .006$). Findings also suggested that family support, such as a spouse or partner, was associated with less severe psychological trauma symptoms. One limitation to Smith et al.'s study is that it did not look at long term effects of coping.

Monson et al. (2017) did a longitudinal examination of the impact of trauma and PTSD diagnosis on global and specific domains of quality of life within a Canadian sample of 2,433 participants. They found that a current diagnosis of PTSD indicated a negative impact on quality of life for subscale and global scores, as well as long-term effects on all quality-of-life outcomes. This study did not look at the length of time an individual has had of PTSD, nor the length of time since remission from PTSD. However, this study did look at individuals across a long period of time.

Bosch et al. (2020) analyzed multiple types of childhood trauma and quality of life outcomes after women had received cognitive processing therapy (CPT). They found that women who encountered more types of childhood trauma reported greater PTSD symptoms; nonetheless they did not report significantly lower quality of life at baseline. They also found that women who had more types of childhood trauma experienced less PTSD symptom reductions after CPT. With each adverse childhood event, women reported an average of a 3.1-point boost in scores on the Clinician Administered PTSD Scale for DSM–IV scores following

treatment. Overall, regardless of history of trauma, women reported small progress with their quality of life after CPT. One limitation to this study, is that it only looked at women's subjective quality of life and not their objective quality of life (e.g., number of days absent from work).

Perceived social support is defined as an individual's perception or experience when he or she receives security, value, respect, love, and care from others (Prakash & Srivastava, 2020). Mesidor and Sly (2019) explored the relationship among PTSD symptoms, posttraumatic growth, resilience, coping strategies, and perceived social support in Haiti Earthquake survivors. Results revealed that active coping, religious coping, and perceived social support were positively related with posttraumatic growth. The greatest predictor of posttraumatic growth was positive religious coping. Individuals who participated in religious coping were more likely to undergo posttraumatic growth. A limitation to this study is that causal relationships could not be drawn.

Songwathana et al. (2016) investigated predictive factors of income, employment, time after injury, experience of losing family members, time disability and environment-related factors of perceived security including life social support that may impact the quality of life of trauma survivors living in the middle of an unrest area in the southernmost provinces of Thailand. Results suggested that disability, employment, social support, and feeling secure from the unrest predicted the quality of life of these trauma survivors; together they accounted for 47% of the variance of quality of life of trauma survivors. A limitation to their study is that they could not get trauma survivors from different locations, thus limiting generalizability.

McIlveen et al. (2019) explored the role of alienation appraisals in student and clinical samples, measuring whether alienation appraisals significantly mediated the relationship between cumulative trauma and markers of trauma related distress. They also analyzed whether other

factors, including social support, alexithymia, and loneliness, mediated the relationship between cumulative trauma and markers of trauma-related distress. Alienation significantly predicted posttraumatic stress across student and clinical samples. Social support, alexithymia, and loneliness did not explain the mediating role of alienation and posttraumatic stress. Nonetheless, alienation appraisals, along with the smaller predictors of social support and loneliness, are factors to recognize in trauma survivors with depression. A limitation of this study was it is not easily generalized, as the students consisted of highly educated females in Northern Ireland.

Wang et al. (2020) examined the mediating role of depressive symptoms on the relationship of social support and quality of life amidst an elderly sample in China. Results suggested that depressive symptoms mediated the relationship among social support and quality of life. It granted evidence that social support might affect quality of life through psychological factors. Ultimately, poor quality of life was related to low social support and an increase in depressive symptoms. One limitation is comorbid factors such as chronic disease, diet, exercise, daily living, and financial resources were not assessed.

Kaniasty (2012) analyzed deterioration and mobilization dynamics of post disaster social support and aid emerging within the first 12 months following a natural disaster. Data were collected from 285 participants who experienced a severe flood in Poland in 1997. Results underscored the importance of both the social support mobilization and social support deterioration models for trauma theory. A limitation was that the assessments of both the outcome and predictor variables were based upon retrospective self-reports at the times when participants also displayed heightened levels of psychological distress. Therefore, negative

evaluations of post flood altruistic communities (e.g., bitterness) and later adverse assessments of interpersonal and communal relationships could have reflected negativity rooted in distress.

Research has indicated that social support lowers posttraumatic stress severity by diminishing negative appraisals succeeding a trauma, illustrating a buffer effect (Woodward et al., 2015). The purpose of this study is to compare the long-term quality of life of individuals who undergo human and natural trauma. A crucial resilience and recovery factor in trauma is perceived social support (Rooke & De Terte, 2020). We hypothesize that with perceived social support held constant, individuals will have a better quality of life following natural trauma than human trauma.

Chapter 2

Methods

Participants

Participants consisted of 136 American adults, ages 17 years and up. Participants included 56 males (41.2%), 79 females (58.1%), and 1 who identified has other (0.8%). Participants were recruited from the data survey Mechanical Turk. Participants from Mechanical Turk were given a $10 Amazon credit. In this study, participants age ranged between 17 and 65+ years old. The modal age was the group with ages between 18 and 24 years old. There were 8 (4.7%) Asian Americans, 9 (5.3%) African American, 1 (0.6%) American Indian or Alaska Native, 91 (53.5%) White, 17 (10%) Latinos, 7 (4.1%) mixed and 3 (1.81%) of participants that identified as other; 34 (20%) did not respond. Regarding education levels there was 23.5% that completed high school or received a GED, 4.1% had an associate degree, 14.7% had some college, 23.5% had a bachelor's degree, 14% had a master's degree, 1.5% had a doctorate and 0.7% of participants had a professional degree. With respect to income, 7.4% had an income

under $15,000, 12.6% had an income between $15,000 and $29,999, 23.7% had an income between $30,000 and $49,999, 20% had an income between $50,000 and $74,999, 13.3% had an income between $75,000 and $99,999, 14.8% had an income become $100,000 and $150,000, and 8.1% had an income over $150,000.

Measures

Demographics Form

This form was used to collect descriptive information. It asked about participants age, gender, ethnicity, household income, and educational level. Ages were gathered in groups: 17–24, 25–34, 35–44, 45–54, 55–64, and 65+ years.

Predictors

Adverse Childhood Experiences. The Adverse Childhood Experiences (ACE; Felitti, 1998) retrospectively assesses adversities experienced in childhood in three areas, including physical and emotional neglect, physical and emotional abuse, and abuse associated with living in a dysfunctional household (Felitti et al., 1998). It includes ten items, each answered with a "yes" or "no" response (Felitti et al., 1998). Scores range from 0 to 10. The higher an individual's score, the greater chance of developing health problems. Cronbach's alpha coefficients was .77 which indicates good internal consistency (Bufford et al., 2017). The current study found a coefficient alpha of .83.

Cumulative Trauma Scale. The Cumulative Trauma Scale (CTS; Kira & Lewandowski, 2008) is a 22-item scale that assesses the kinds of traumatic events experienced by an individual (e.g., war, rape, torture, abandonment by parent, sexual and physical abuse, car accidents, or natural disasters). Responses are in a "yes" or "no" format. Cronbach alpha coefficient was .81, which indicated good internal consistency. The CTS also has good concurrent validity.

Exploratory factor analysis found that six factors accounted for 58.73% of the variance: family trauma (e.g., divorce and family history of violence), discriminated against or threatened due to race or ethnicity or religion, collective identity trauma (e.g., 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 for the first five factors, at .95 indicating good fit. The current study found a coefficient alpha of .88.

Natural Disaster Assessment. Examination of the CTS revealed that it has only one item (Merrell et al., 2013) related to natural trauma; for all practical purposes it is a measure of human trauma. To better assess natural trauma, a new scale was developed for this study. There were twelve items, each answered with a "yes" or "no" response. The current study found a coefficient alpha of .83.

Moderator

Multidimensional Scale of Perceived Social Support . The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al, 1988, 1990) is a 12-item questionnaire that measures an individual's perceived adequacy of support from friends, family, and their significant other. Items on the MSPSS utilize a 7-point Likert scale ranging from 1 (*very strongly disagree*) to 7 (*very strongly agree*). The MSPSS has good internal reliability, ranging from .81 to .90. The MSPSS demonstrates strong factorial validity. In a prepartum sample, Zimet et al. reported a mean of 6.01 (*SD* = 0.90) among adolescent high schoolers in Madrid or Paris, a mean of 5.60 (*SD* = 0.80), and a mean of 5.58 (*SD* 0.98) among 1st- and 2nd-year pediatric residents in the Cleveland area. The current study found a coefficient alpha of .94.

Criterion Measures

International Trauma Questionnaire. Impact of Events Scale-Revised (IES-R; Weiss & Marmar, 1997). The IES-R is a 22-item scale that measures an individual distress from a traumatic event (Creamer, et.al., 2002). Items are responded to on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*). Cronbach's alpha was .96, which indicated high internal consistency. The current study found a coefficient alpha of .96.

International Trauma Questionnaire. The International Trauma Questionnaire (ITQ; Cloitre et al., 2018) is an 18-item scale that assesses and distinguishes PTSD and complex PTSD. Item responses are on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*). Cronbach's alpha was .89, which indicates good internal consistency (Camden et al., 2023). The current study found a coefficient alpha of .92. The scale has two major subscales with three symptom clusters in each. The first subscale is simple PTSD with the symptom clusters of re-experiencing, avoidance, and sense of threat. The second subscale is complex PTSD, this consists of affective dysregulation, negative self-concept, and disturbances in relationships. Complex PTSD is diagnosed if the criteria for PTSD are met and criteria for Complex PTSD are met. For this study, the ITQ was broken into two parts: ITQA for PTSD and ITQB for complex PTSD.

Satisfaction with life scale. The Satisfaction with life scale (SWLS; Pavot & Diener, 1993) is a five-item scale that assesses cognitive judgments of satisfaction with one's life. Responses on the SWLS use a 7-point Likert scale that ranges from 1 (*strongly disagree*) to 7 (*strongly agree*). Higher scores are indicative of being more satisfied with life. The SWLS has good convergent validity. In a sample of older adults, prisoners, individuals under inpatient care for alcohol abuse, abused women, psychotherapy clients, elderly caregivers of demented spouses, individuals with physical disabilities, and college student samples, Pavot and Diener

(1993), reported a mean of 4.71 (*SD* = 1.47) on the first item, a mean of 4.74 (*SD* = 1.52) on the second item, a mean of 5.23 (1.52) on the third item, a mean of 4.75 (*SD* = 1.75) on the fourth item, and a mean of 4.25 (1.86) on the fifth item.). Cronbach's alpha was .87, which indicated high internal consistency; in the present sample, alpha was .96.

Procedure

Participants were presented with an informed consent form that described the study and estimated time to complete participation; agreeing to proceed was treated as consent. Checking agree was followed by the survey, including instructions for each measure. The measures were given in random order. Prior to completing all the surveys, participants filled out a demographic information form. All questionnaires were completed online using Surveymonkey.com and Mechanical Turk.

Data Analysis

Descriptive statistics and alpha coefficients were computed. The relationship between social support and human and natural trauma were examined by means of hierarchical regression to predict overall impact of distressing life events and subjective wellbeing while controlling for social support. Model 1 controlled for demographic factors including age, gender, and ethnic identity. Model 2 included MPSS to control for social support. Model 3 added natural or human trauma measures. Criterion variables included the IES-R, ITQA and ITQB based on the ITQ, and SWLS.

Chapter 3

Results

We hypothesize that with perceived social support held constant, individuals will have a better quality of life following natural trauma than human trauma. Results showed that all

measures had good internal consistency; alphas ranged from .83 to .96. Descriptive statistics were computed for the measures of ACEs, CTS, MSPSS, Natural Disaster Assessment (NDA), ITQ, IES-R, and the SWLS. Table 1 provides these descriptive data. The measure of the ACE's had 150 responses with a mean of 2.19 and a standard deviation of 2.56. CTS had 148 responses with a mean of 23.74 and a standard deviation of 3.96, while the measure of the SWLS had 151 responses with a mean of 24.07 and a standard deviation of 7.21. The MSPSS had 152 responses with a mean of 65.39 and a standard deviation of 15.65. ITQA had 135 responses with a mean of 18.05 and a standard deviation of 8.48. ITQB had 135 responses with a mean of 18.19 and a standard deviation of 8.62. The IES-R had 148 responses with a mean of 46.77 and a standard deviation of 21.21 (see Table 1).

Table 1

Descriptive Data for Scores on Predictor, Criterion, and Outcome Variables

Variable	α	*N*	*SD*	*M*	Skew	Kurtosis
Predictors						
ACE	.83	150	2.56	02.19	-1.30	1.21
CTS	.88	148	3.96	23.74	-2.47	7.17
MSPSS	.94	152	15.65	65.39	-1.32	1.53
NDA	.83	141	3.13	33.28	-3.08	11.97
ITQA	.92	135	8.48	18.05	0.88	-.04
ITQB	.92	135	8.62	18.19	.91	.24
Criteria						
IES-R	.96	151	21.21	46.77	0.69	-.28
SWLS	.91	151	7.21	24.07	-0.70	-.14

Note. ACE = Adverse Childhood Experiences; CTS = Cumulative Trauma Scale; SWLS = Satisfaction with life scale; IES-R = Impact of Events Scale-Revised; NDA = Natural Disaster Assessment; ITQA International Trauma Questionnaire pt. 1; ITQB International Trauma Questionnaire pt. 2.

Correlational Findings

Correlational results showed that age and education were significantly related to each other as expected (r = .335; p < .01), but unrelated to the study measures except that age showed a small negative correlation with the NDA (r = -.182; $p \leq .05$). Education was positively correlated with CTS (r = .183, $p \leq .05$), but not with other study measures.

IES-R was negatively correlated with NDA (r = -.246; < .01), positively correlated with ACE's (r = .348; < .01), positively correlated with CTS-R (r = .317; p < .01), positively correlated with ITQ-A (r = .730; < .01), positively correlated with ITQ-B (r = .649; p < .01), and negatively correlated with SWLS (r = -.215; p < .01).

NDA was negatively correlated with age (r = -182; $p \leq .05$) and negatively correlated with ACE's (r = -.498; $p \leq .05$).

CTS was negatively correlated to NDA (r = -.719; p < .01), positively correlated with ACE's (r = .626; p < .01), negatively correlated with MSPSS (r = -.312; p < .01), positively correlated with IES-R (r = .317; p < .01), positively correlated with ITQ-A (r = .319; p < .01), positively correlated with ITQ-B (r = .295; p < .01), and unrelated to SWLS.

ITQ-A was negatively correlated with NDA (r = -.225; $p \leq .05$), positively correlates with ITQ-B (r = .666; p < .01), and negatively correlated with SWLS (r = -.230; p < .01). ITQ-B was negatively correlated with NDA (r = -.199, $p \leq .05$), and negatively correlates with SWLS (r = -.230; p < .01).

ACEs was negatively correlated with MSPSS (r = -.414; p < .01), positively correlated with IES-R (r = 348; p < .01), positively correlated with ITQ-A (r = 318; p < .01), and positively correlated with ITQ-B (r = -.430; p < .001).

MSPSS was negatively correlated with ITQ-B (r = -298; p < .01) and positively correlated with SWLS (r = .281; p < .01; see Table 2).

Table 2

Correlations Between Select Demographics Items, Independent Measures and Dependent Measures

Variable	1	2	3	4	5	6	7	8	9
1 Age									
2 Education	.335**								
3. NDA	-.182*	-.154							
4. ACEs	-.060	-.108	-.498**						
5. CTS	.112	.183*	-.719**	.626**					
6. MSPSS	-.060	-.005	-.133	-.414**	-.312**				
7. IES-R	-.049	.125	-.246**	.348**	.317**	-.135			
8. ITQ-A	-.009	.032	-.225*	.318**	.319**	-.072	.730**		
9. ITQ-B	.000	.057	-.199*	.430**	.295**	-.298**	.649**	.666**	
10. SWLS	-.146	-.050	.145	-.050	.054	.281**	-.215**	-.230**	-.509**

Note. *N* is 135 or greater. ACE = Adverse Childhood Experiences; CTS = Cumulative Trauma Scale; SWLS = Satisfaction with life scale; IES-R = Impact of Events Scale-Revised; NDA = Natural Disaster Assessment; ITQA International Trauma Questionnaire pt. 1; ITQB International Trauma Questionnaire pt. 2.

*Correlation is significant at the 0.05 level.

**Correlation is significant at the 0.01 level.

The research hypothesis that individuals will have a better quality of life following natural trauma than following human trauma with perceived social support held constant was tested by means of hierarchical regression. The relationships of natural and human trauma to wellbeing were examined by means of hierarchical regressions to predict overall impact of

distressing life events on trauma symptoms and subjective wellbeing while controlling for demographic factors and social support. For each regression, Model 1 controlled for demographic factors including age, gender, ethnic identity, household income, and education. Model 2 included MPSS to control for social support. Model 3 added natural or human trauma measures. Dependent variables included the IES-R, ITQA and ITQB as well as the SWLS.

Natural Trauma

Natural trauma was assessed by NDA, a new scale developed for the purpose of this study. The predictive significance of natural trauma for dependent measures was assessed by four hierarchical regressions. In predicting IES-R, demographic factors were not significant in Model 1. Social support was also not significant in Model 2. However, in Model 3, natural trauma significantly contributed to IES-R ($F_{7,118} = 2.93$, $p = .007$; $R = .385$, $R^2 = .148$, $\Delta R^2 = .059$; for NDA $\beta = -.261$, $t = -2.87$, $p = .005$). In all, 14.8% of the IES-R variance was accounted for; NDA accounted for 5.9% after controlling for demographics and MSPSS (see Table 3)**.**

Table 3

Hierarchical Regression Predicting Effects of Natural Trauma on the IES-R While Controlling for Demographic Differences and Social Support

Variable	*F*	*df*	*sig*	*R*	R^2	ΔR^2	β	*t*	Sig.
Model 1	1.93	5,120	.094	.273	.075	.075			
Age							–.13	–1.36	.177
Gender							–.09	–1.03	.304
Ethnicity							–.03	–0.32	.752
SES							–.15	–1.71	.090
Level of Education							.25	2.53	.013
Model 2	1.93	6,119	.082	.298	.089	.014			
Age							–.15	–1.51	.134

Variable	*F*	*df*	*sig*	*R*	R^2	ΔR^2	β	*t*	Sig.
Gender							–.08	–.92	.357
Ethnicity							–.02	–.23	.818
SES							–.13	–1.46	.147
Level of Education							.26	2.62	.010
MSPSS							–.12	–1.36	.178
Model 3	2.93	7,118	.007	.385	.148	.059			
Age							–.17	–1.77	.080
Gender							–.14	–1.54	.126
Ethnicity							–.02	–0.23	.820
SES							–.10	–1.11	.271
Level of Education							.23	2.41	.018
MSPSS							–.07	–0.81	.419
NDA							–.26	–2.87	.005

Note. SES = socioeconomic status; MSPSS= Multidimensional Scale of Perceived Social Support; NDA = Natural Disaster Assessment; IES-R= Impact of Events Scale-Revised; SWLS=Satisfaction with life scale.

In predicting ITQA, Models 1 and 2 did not have significance. Model 3 was-also not significant overall; but natural trauma had a small relationship in predicting ITQA ($F_{1,118} = 1.18$, $p = .332$; $R = .262$, $R^2 = .069$, $\Delta R^2 = .050$; $\beta = -.240$, $t = -2.46$, $p = .015$; see Table 4**).**

Table 4

Hierarchical Regression Predicting the Effects of Natural Trauma on ITQA While Controlling for Demographic Differences and Social Support

Variable	*F*	*df*	*sig*	*R*	R^2	ΔR^2	β	*t*	Sig.
Model 1	.233	5,114	.948	.100	.010	.010			
Age							–.045	-.43	.665
Gender							–.042	–.44	.661

Variable	*F*	*df*	*sig*	*R*	R^2	ΔR^2	β	*t*	Sig.
Ethnicity							–.048	–0.50	.618
SES							–.02	–.22	.830
Level of Education							.09	.89	.375
Model 2	.349	6,113	.909	.135	.018	.008			
Age							–.06	–0.54	.590
Gender							–.04	–0.37	.710
Ethnicity							–.04	–0.45	.657
SES							–.00	–0.04	.969
Level of Education							.10	0.94	.348
MSPSS							–.09	–0.97	.337
Model 3	1.18	7,112	.322	.262	.069	.050			
Age							–.08	–0.74	.464
Gender							–.09	–0.90	.371
Ethnicity							–.04	–0.43	.667
SES							.02	0.26	.799
Level of Education							.08	0.77	.444
MSPSS							–.04	–0.46	.644
NDA							–.24	–2.46	.015

Note. SES = socioeconomic status; MSPSS = Multidimensional Scale of Perceived Social Support; NDA = Natural Disaster Assessment; ITQA International Trauma Questionnaire pt. 1.

In predicting ITQB, demographic variables were not significant in Model 1. In Model 2, MSPSS was a significant predictor ($F_{6,114} = 3.16$, $p = .007$; $R = .377$, $R^2 = .142$, $\Delta R^2 = .090$, β = -.310, $t = -3.47$, $p = .001$). In Model 3, there was a slight increase in predictive variability; MSPSS remained a predictor, but natural trauma did not prove to be a significant factor ($F_{7,113} = 3.27$, $p = .003$; $R = .410$, $R^2 = .168$, $\Delta R^2 = .026$; for NDA, β = -.172, $t = -1.88$, $p = 06.$; see Table 5)**.**

Table 5

Hierarchical Regression Predicting the Effects of Natural Trauma on ITQB While Controlling for Demographic Differences and Social Support

Variable	*F*	*df*	*sig*	*R*	R^2	ΔR^2	β	*t*	Sig.
Model 1	1.26	5, 115	.285	.228	.052	.052			
Age							-.019	-.188	.851
Gender							-.142	-1.51	.133
Ethnicity							-.121	-1.31	.194
SES							-.107	-1.15	.252
Level of Education							.124	1.24	.219
Model 2	3.16	6,114	.007	.377	.142	.090			
Age							-.057	-.587	.558
Gender							-.120	-1.33	.185
Ethnicity							-.105	-1.18	.239
SES							-.051	-.562	.575
Level of Education							.143	1.49	.139
MSPSS							-.310	-3.47	<.001
Model 3	3.27	7, 113	.003	.410	.168	.026			
Age							-.071	-.736	.464
Gender							-.157	-1.72	.088
Ethnicity							-.102	-1.17	.246
SES							-.031	-.341	.734
Level of Education							.128	1.35	.181
MSPSS							-.275	-3.05	.003
NDA							-.172	-1.88	.063

Note. SES = socioeconomic status; MSPSS = Multidimensional Scale of Perceived Social Support; NDA = Natural Disaster Assessment; ITQB International Trauma Questionnaire pt. 2.

Finally, prediction of SWLS was explored. In Model 1, only age was significant among demographic variables for predicting SWLS ($F_{5,120} = 1.94$, $p = .09$; $R = .274$, $R^2 = .075$; for age $\beta = .241$, $t = 2.44$, $p = .016$). In Model 2, age remained significant and MPSS added significant predictive variance ($F_{6,119} = 11.35$, $p = .001$; $R = .394$, $R^2 = .155$, $\Delta R^2 = .081$; for MSPSS, $\beta = -.292$, $t = -3.37$, $p = .001$). In Model 3, NDA was added as an additional significant predictor ($F_{7,118} = 7.86$, $p = .006$; $R = .456$, $R^2 = .208$, $\Delta R^2 = .053$; for NDA $\beta = .246$, $t = 2.80$, $p = .006$). Together, age, social support, and natural disaster trauma accounted for about 21% of the variance in SWLS, but natural disaster accounted for only about 5% of the total variance (see Table 6).

Table 6

Hierarchical Regression Predicting Effects of Natural Trauma on Satisfaction With Life While Controlling for Demographic Differences and Social Support

Variable	*F*	*df*	*sig*	*R*	R^2	ΔR^2	β	*t*	Sig.
Model 1	1.94	5, 120	.092	.274	.075	0.75			
Age							.24	2.44	.016
Gender							–.12	–1.29	.198
Ethnicity							.02	0.23	.816
SES							–.13	–1.42	.160
Level of Education							–.07	–0.75	.452
Model 2	3.65	6,119	.002	.394	.155	.081			
Age							.20	2.14	.035
Gender							–.09	–1.08	.284
Ethnicity							.04	0.46	.648
SES							–.08	–0.88	.380
Level of Education							–.05	–0.56	.579
MSPSS							–.29	–3.37	.001

Variable	*F*	*df*	*sig*	*R*	R^2	ΔR^2	β	*t*	Sig.
Model 3	4.43	7,118	<.001	.456	.208	.053			
Age							.22	2.41	.018
Gender							–.04	–0.48	.630
Ethnicity							.04	0.46	.646
SES							–.11	–1.27	.206
Level of Education							–.03	–0.30	.760
MSPSS							–.34	–3.94	<.001
NDA							.25	2.80	.006

Note. N = 596; SES = socioeconomic status; ACEs = Adverse Childhood Experiences; NDA = Natural Disaster Assessment; MSPSS = Multidimensional Scale of Perceived Social Support.

In summary, none of the regression Models 1 and 2 did not predict IES-R, but when NDA was included, NDA predicted IES-R, and education was also a predictor in Model 3. Only NDA positively predicted ITQA. MSPSS negatively predicted ITQB, but NDA was not a significant predictor. Finally, social support negatively predicted quality of life, while age and NDA positively predicted quality of life.

Human Trauma

Next, the role of human trauma was examined in a similar manner. In predicting IES-R, Model 1 overall was not significant. In Model 2, social support was not significant, however Level of Education had a very small relationship ($F_{6,126} = 1.39$, $p = .002$; $R = .249$, $R^2 = .062$, $\Delta R^2 = .007$; for level of education, $\beta = .192$, $t = -2.06$, $p = .042$). In Model 3, a significant regression coefficient was found ($F_{8,124} = 3.17$, $p = .003$; $R = .412$, $R^2 = .170$, $\Delta R^2 = .004$), but none of the individual predictors was significant including ACE and CTS (see Table 7).

Table 7

Hierarchical Regression Predicting the Effects of ACE's and CTS on IES-R While Controlling for Demographic Differences and Social Support

Variable	*F*	*df*	*sig*	*R*	R^2	ΔR^2	β	*t*	Sig.
Model 1	1.49	5,127	.198	.235	.055	.055			
Age							–.11	–1.15	.253
Gender							–.05	–.54	.591
Ethnicity							.00	.04	.967
SES							–.17	–1.89	.062
Level of Education							.20	2.10	.038
Model 2	1.39	6,126	.223	.249	.062	.007	–.11	–1.17	.243
Age									
Gender							–.04	–0.39	.700
Ethnicity							.01	0.14	.890
.SES							–.16	–1.75	.082
Level of Education							.19	2.06	.042
MSPSS							–.09	–0.96	.338
Model 3	2.82	8,124	.003	.412	.170	.107			
Age							–.11	–1.26	.209
Gender							–.04	–0.41	.680
Ethnicity							.04	0.44	.660
SES							–.10	–1.09	.277
Level of Education							.13	1.44	.152
MSPSS							.07	0.75	.456
ACE							.22	–1.88	.063
CTS							–.19	–1.71	.090

Note. ACE = Adverse Childhood Experiences; CTS = Cumulative Trauma Scale; IES-R = Impact of Events Scale-Revised; SES = Socioeconomic status; MSPSS = Multidimensional Scale of Perceived Social Support.

With ITQA as a criterion, Model 1 examined the relationship of demographics factors, Model 2 explored the role of social support, and Model 3 added human trauma as measured by the ACE's and CTS. Examination of the relationship of demographic, social support, and natural trauma on ITQA found no significant effects on Models 1 and 2. For Model 3, a significant regression coefficient was again found ($F_{8,118} = 2.28$, $p = .026$; $R = .366$, $R^2 = .134$, $\Delta R^2 = .126$), but none of the individual predictors was significant including ACE and CTS (see Table 8).

Table 8

Hierarchical Regression Predicting the Effects of ACE's and CTS on ITQA While Controlling for Demographic Differences and Social Support

Variable	*F*	*df*	*sig*	*R*	R^2	ΔR^2	β	*t*	Sig.
Model 1	.06	5,121	.998	.050	.002	.002			
Age							–.02	–.22	.830
Gender							.01	–.07	.943
Ethnicity							–.02	–.22	.827
SES							–.03	–.27	.791
Level of Education							.05	.48	.636
Model 2	.15	6,120	.989	.087	.008	.005			
Age							–.02	–.*24*	.813
Gender							.00	.05	.964
Ethnicity							–.01	–.14	.886
SES							–.02	–.16	.872
Level of Education							.04	.43	.670
MSPSS							–.07	–.78	.438
Model 3	2.28	8,118	.026	.366	.134	.126			
Age							–.02	–.23	.816
Gender							.01	.06	.954
Ethnicity							.02	.18	.859

Variable	*F*	*df*	*sig*	*R*	R^2	ΔR^2	β	*t*	Sig.
SES							.05	.49	.622
Level of Education							–.02	–.21	.832
MSPSS							.10	1.00	.320
CTS							–.21	–1.83	.071
ACE							.24	–1.92	.058

Note. SES = socioeconomic status; MSPSS = Multidimensional Scale of Perceived Social Support; ACEs = Adverse Childhood Experiences; CTS = Cumulative Trauma Scale; ITQA International Trauma Questionnaire pt. 1.

When exploring the relationship of demographics and human trauma on ITQB, demographics did not contribute a significant effect for Model 1. Model 2 also did not reach significance, though MSPSS showed a small relationship with ITQB (β = -.25 *t* = -2.86, *p* = .005). Model 3 showed that the addition of ACE's and CTS contributed predictive variances ($F_{8,119}$ = 3.91, *p* = < .001; *R* = .456, R^2 = .208, ΔR^2 = .117); CTS did not prove to be a significant factor; however, ACEs was significant. (β = -.39, *t* = -.3.31, *p* = .001) and MSPSS ceased to be significant with ACEs added (see Table 9).

Table 9

Hierarchical Regression Predicting the effect of ACE's and CTS on ITQB While Controlling for Demographic Differences and Social Support

Variable	*F*	*df*	*sig*	*R*	R^2	ΔR^2	β	*t*	Sig.
Model 1	.75	5,122	.587	.173	.030	.030			
Age							–.02	–0.25	.801
Gender							-.08	–0.89	.373
Ethnicity							–.10	–1.11	.268

Variable	*F*	*df*	*sig*	*R*	R^2	ΔR^2	β	*t*	Sig.
SES							–.11	–1.15	.254
Level of Education							.09	0.95	.345
Model 2	2.03	6,121	.067	.302	.091	.061			
Age							–.03	–0.34	.738
Gender							–.04	–0.48	.633
Ethnicity							–.08	–0.88	.381
SES							–.07	–0.80	.428
Level of Education							.08	0.81	.418
MSPSS							–.25	–2.86	.005
Model 3	3.91	8,119	<.001	.456	.208	.117			
Age							–.03	–0.38	.704
Gender							–.00	–0.02	.983
Ethnicity							–.07	–0.83	.406
SES							–.01	–0.08	.937
Level of Education							.02	–0.27	.792
MSPSS							–.09	–0.96	.340
CTS							–.01	–0.10	.921
ACE							.39	3.31	.001

Note. SES = socioeconomic status; MSPSS = Multidimensional Scale of Perceived Social Support; CTS = Cumulative Trauma Scale; ACE = Adverse Childhood Experiences; ITQB International Trauma Questionnaire pt. 2.

Finally, in predicting SWLS scores, demographic variables in Model 1 fell short of significance though age was significantly related to SWLS. Social support in Model 2 was a significant predictor for SWLS ($F_{6,126} = 3.25$, $p = .005$; $R = .366$. $R^2 = .134$, $\Delta R^2 = .057$; β = -.244, $t = -2.88$, $p = .005$) and age continued to be a predictor. In Model 3, age and social support

contributed significantly to SWLS ($F_{8,124}$ = 3.02, p = .004; R = .404, R^2 = .163; ΔR^2 = .029; for MSPSS β = -.313, t = -.335, p = .001), but neither CTS nor ACEs were predictors (see Table 10).

Table 10

Hierarchical Regression Predicting the Effects of Human Trauma and Satisfaction With Life While Controlling for Demographic Differences and Social Support

Variable	*F*	*df*	*sig*	*R*	R^2	ΔR^2	β	*t*	Sig.
Model 1	2.13	5,127	.066	.278	.077	.077			
Age							.24	2.53	.013
Gender							–.09	–1.05	.296
Ethnicity							.02	0.20	.844
SES							–.14	–1.60	.113
Level of Education							–.07	–0.78	.437
Model 2	3.25	6,126	.005	.366	.134	.057			
Age							.23	2.52	.013
Gender							–.06	–0.63	.531
Ethnicity							.04	0.49	.624
SES							–.11	–1.27	.206
Level of Education							–.08	–0.93	.355
MSPSS							–.24	–2.88	.005
Model 3	3.02	8,124	.004	.404	.163	.029			
Age							.23	2.54	.012
Gender							–.04	–0.42	.678
Ethnicity							.02	0.26	.799
SES							–.14	–1.56	.122
Level of Education							–.05	–0.56	.574
MSPSS							–.31	–3.35	.001
CTS							.16	1.45	.149
ACE							–.04	–0.31	.756

Note. SES = socioeconomic status; MSPSS = Multidimensional Scale of Perceived Social Support; CTS = Cumulative Trauma Scale; ACE = Adverse Childhood Experiences.

In summary, regression results for ACEs and CTS showed that among demographic variables, gender, ethnicity, and SES did not enter in any of the regressions. However, education entered as a predictor of IES-R in Models 1 and 2, and age entered as a predictor of SWLS in all three models. MSPSS was a significant negative predictor in Model 2 for both ITQB and SWLS. MSPSS was not a significant predictor in Model 3 for ITQ-B, but remained significant in Model 3 for SWLS. Finally, ACEs was a significant positive predictor of ITQB in Model 3.

Chapter 4

Discussion

We hypothesized that with perceived social support held constant, individuals will have a better quality of life following natural trauma than human trauma. Results suggested social support negatively impacts trauma severity. The more social support you have, the less likely you will report more trauma symptoms. ACEs also revealed that the higher your ACE score, the more likely you will report complex trauma symptoms. We also saw that level of education negatively impacts Simple Trauma. The more education you have, the less likely you are to report simple PTSD symptoms. These findings each had a small effect.

Another finding was that social support and quality of life were inversely related; while causality is not clear, this finding suggests that those experiencing lower quality of life are more apt to seek social support. This was a small effect. Results also suggested that both age and natural trauma impact quality of life. The older you are, the better quality of life you have. Surprisingly results revealed the more natural trauma you have, the better quality of life you have. Both effects were small. Perhaps exposure to natural trauma contributed to resilience or well-being in this sample. The last finding, we found was natural trauma is associated with fewer

complex trauma symptoms. The more natural trauma one has, the less likely they are to report complex PTSD. This result was unexpected; it suggests that overall, exposure to natural trauma is associated with greater resourcefulness in dealing with human trauma.

Table 11

Overview of Findings

Independent Variable	Relationship	Effect Size	Dependent Variable
Age	+	.24-Small	SWLS
MSPSS	-	.29-Small	Quality of Life & Complex Trauma severity
NDA	+	.25 Small	Quality of Life
Education	-	.24 Small	IES-R

Note. MSPSS= Multidimensional Scale of Perceived Social Support; NDA = Natural Disaster Assessment; IES-R= Impact of Events Scale-Revised; SWLS=Satisfaction with life scale.

Regarding interpersonal relationships and experiences, results were consistent. Results suggested social support negatively impacts Trauma Severity. The more social support you have, the less likely you will report more trauma symptoms. ACEs also revealed the higher your ACE score, the more likely you will report trauma symptoms. This is consistent with Monson et. al. (2015). The harmful impacts of PTSD continue to linger in specific categories of quality of life (i.e., personal relationships) over others, or vice versa, that lower quality of life in certain domains at the time of exposure increases risk of sustained PTSD.

Results also suggested that natural trauma is associated with fewer complex trauma symptoms. The more natural trauma one has, the less likely they are to report complex PTSD.

We also found that natural trauma impacts quality of life more than human trauma. Unexpectedly, the more natural trauma you have, the better quality of life you have. Both effects were small. This result was inconsistent with Dhungana et al. (2021). Quality of life is a significant indicator of health and has various dimensions. It is negatively affected in patients with trauma history, and psychiatric disorders play a crucial role therein. Dhugana et al. examined various aspects of quality of life in trauma patients in a clinical setting, mainly focusing on the association of psychiatric disorders on various domains of quality of life. They found that both natural disaster and human trauma adversely affect quality of life in their patient sample. Those patients with history of various traumas and those who perceive trauma as life-threatening were more susceptible to having poor quality of life (Dhungana et al., 2021). These data suggest that more attention should be given to factors that may influence the adverse effects of natural trauma.

Our study found that social support and quality of life had an inverse relationship. This finding suggests that those experiencing lower quality of life are more apt to seek social support. This was a small effect. This is inconsistent with Shakespeare-Finch et al. (2019). Giving, as well as receiving social support on psychological outcomes in two trauma-exposed samples: flood survivors and firefighters was studied by Shakespeare-Finch et al. (2019). Results suggested that although giving social support revealed a significant bivariate relationship with depression and stress in the firefighter sample, the important contribution of giving social support was found only for posttraumatic growth. These findings suggest that the value of examining both giving and receiving and social support, as they may have differential influence in buffering against the impact of trauma exposure on psychological outcomes.

Limitations & Implications

Future studies should identify what long term means to the participant. Participants were not given a time frame for their trauma, so this information could be within 2 days, 5 years, etc. Future studies could also utilize participants with confirmed trauma, as this study was given out to random participants, and they may or may not have experienced a trauma. Future studies could also use a cross sectional sample. Using different ages can give experimenters more insight on social support and the trauma relationship across the lifespan. Studying the relationship between social support and trauma could help those who are struggling with trauma, because it could be a precursor for individuals to seek out support, rather than isolating and creating more decline in one's mental health.

Conclusion

This study analyzed the quality of life among those who have experienced a natural trauma or a human trauma, with demographic factors and social support held constant. Results revealed that social support negatively impacts Trauma Severity. Surprisingly, ACEs also revealed the higher your ACE score, the more likely you will report complex trauma symptoms. We also saw that level of education positively impacts Simple Trauma. Another finding was that social support and quality of life were inversely related. Results also suggested that age and natural trauma impact quality of life. Surprisingly, the more natural trauma you have, the better quality of life you have. The last finding, we found was natural trauma is associated with fewer complex trauma symptoms. Overall, results clearly differ for natural and human trauma. It appears human trauma may accompany natural trauma and divert attention from natural trauma or alter its impact.

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Appendix A

Demographic Characteristics of the Sample

Variable	Median	n	%	M(SD)
Age	3.0			3.12
Under 18		3	1.8	
18-24		52	30.6	
25-34		37	21.8	
35-44		24	14.1	
45-54		13	7.6	
55-64		7	4.1	
65+		1	0.6	
Gender	1.0			1.4
Female		79	46.5	
Male		56	32.9	
Other		1	.6	
Ethnicity	1.0			1.8
White or Caucasian		91	53.5	
Black or African American		9	5.3	
Hispanic or Latino		17	10.0	
Asian or Asian American		8	4.7	
American Indian or Alaska Native		1	.6	
Mixed		7	4.1	
Other		3	1.8	
Household Income	4.0			3.9
Under $15,000		10	5.9	
Between $15,000 and $29,999		17	10.0	
Between $30,000 and $49,999		32	18.8	
Between $50,000 and $74,999		27	15.9	
Between $75,000 and $99,999		18	10.6	

Between $100,000 and $150,000		20	11.8	
Over $150,000		11	6.5	
Highest level of Education	**4.0**			**4.2**
High School or GED		40	23.5	
Associates Degree		7	4.1	
Some college		25	14.7	
Bachelor's Degree & up		40	23.5	

Appendix B

The Satisfaction with Life Scale

DIRECTIONS: Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number in the line preceding that item. Please be open and honest in your responding.

1 = Strongly Disagree 2 = Disagree 3 = Slightly Disagree 4 = Neither Agree nor Disagree 5 = Slightly Agree 6 = Agree 7 = Strongly Agree

_____1. In most ways my life is close to my ideal.

_____2. The conditions of my life are excellent.

_____3. I am satisfied with life.

_____4. So far, I have gotten the important things I want in life.

_____5. If I could live my life over, I would change almost nothing.

Appendix C

Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often …Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?

Yes, No If yes enter 1 _____

2. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?

Yes, No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever…Touch or fondle you or have you touch their body in a sexual way? Or try to or actually have oral, anal, or vaginal sex with you?

Yes, No If yes enter 1 _____

4. Did you often feel that … No one in your family loved you or thought you were important or special? Or Your family didn't look out for each other, feel close to each other, or support each other?

Yes, No If yes enter 1 _____

5. Did you often feel that …You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes, No If yes enter 1 _____

6. Were your parents ever separated or divorced?

Yes, No If yes enter 1 _____

7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? Or sometimes or often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes, No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes, No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes, No If yes enter 1 _____

10. Did a household member go to prison?

Yes, No If yes enter 1 _____

Now add up your “Yes” answers: _____ This is your ACE Score

Appendix D

Multidimensional Scale of Perceived Social Support

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree** Circle the "2" if you **Strongly Disagree** Circle the "3" if you **Mildly Disagree** Circle the "4" if you are **Neutral** Circle the "5" if you **Mildly Agree** Circle the "6" if you **Strongly Agree** Circle the "7" if you **Very Strongly Agree**

1. There is a special person who is around when I am in need. 1 2 3 4 5 6 7
2. There is a special person with whom I can share joys and sorrows. 1 2 3 4 5 6 7
3. My family really tries to help me. 1 2 3 4 5 6 7
4. I get the emotional help & support I need from my family. 1 2 3 4 5 6 7
5. I have a special person who is a real source of comfort to me. 1 2 3 4 5 6 7
6. My friends really try to help me. 1 2 3 4 5 6 7
7. I can count on my friends when things go wrong. 1 2 3 4 5 6 7
8. I can talk about my problems with my family. 1 2 3 4 5 6 7
9. I have friends with whom I can share my joys and sorrows. 1 2 3 4 5 6 7
10. There is a special person in my life who cares about my feelings. 1 2 3 4 5 6 7
11. My family is willing to help me make decisions. 1 2 3 4 5 6 7
12. I can talk about my problems with my friends. 1 2 3 4 5 6 7

Appendix E

Cumulative Trauma Survey

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 F

International Trauma Questionnaire

Instructions: Please identify the experience that troubles you most and answer the questions in relation to this experience.

Brief description of the experience _____

When did the experience occur?

A. less than 6 months ago

B. 6 to 12 months ago

C. 1 to 5 years ago

D. 5 to 10 years ago

E. 10 to 20 years ago

F. more than 20 years ago

Below are a number of problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then circle one of the numbers to indicate how much you have been bothered by that problem in the past month. 0=Not at all, 1= A little bit, 2=Moderately, 3= Quite a bit, 4=Extremely

1. Having upsetting dreams that replay part of the experience or are clearly related to the experience?

0 1 2 3 4

2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?

0 1 2 3 4

3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?

0 1 2 3 4

4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?

0 1 2 3 4

5. Being “super-alert”, watchful, or on guard?

0 1 2 3 4

6. Feeling jumpy or easily startled?

0 1 2 3 4

7. In the past month have the above problems: Affected your relationships or social life?

0 1 2 3 4

8. In the past month have the above problems: Affected your work or ability to work?

0 1 2 3 4

9. In the past month have the above problems: Affected any other important part of your life such as parenting, or school or college work, or other important activities?

0 1 2 3 4

Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you typically feel, ways you typically think about yourself and ways you typically relate to others. Answer the following thinking about how true each statement is of you. 0=Not at all, 1= A little bit, 2=Moderately, 3= Quite a bit, 4=Extremely

1. When I am upset, it takes me a long time to calm down.

0 1 2 3 4

2. I feel numb or emotionally shut down.

0 1 2 3 4

3. I feel like a failure.

0 1 2 3 4

4. I feel worthless.

0 1 2 3 4

5. I feel distant or cut off from people.

0 1 2 3 4

6. I find it hard to stay emotionally close to people.

0 1 2 3 4

7. In the past month, have the above problems in emotions, in beliefs about yourself and in relationships: Created concern or distress about your relationships or social life?

0 1 2 3 4

8. In the past month, have the above problems in emotions, in beliefs about yourself and in relationships: Affected your work or ability to work?

0 1 2 3 4

9. In the past month, have the above problems in emotions, in beliefs about yourself and in relationships: Affected any other important parts of your life such as parenting, or school or college work, or other important activities?

0 1 2 3 4

Appendix G

Natural Disaster Assessment

1. Have you experienced a natural disaster?

   Yes No

2. Did you witness anyone die during/after the natural disaster?

   Yes No

3. Did you get injured during the natural disaster?

   Yes No

4. Did you lose your home after the natural disaster?

   Yes No

5. Did you experience property damage to your home after the disaster?

   Yes No

6. Did you know the disaster was coming? If yes, were you prepared?

   Yes No.

   Yes, I was prepared. No, I was not prepared

7. Are you worried about another natural disaster happening?

   Yes No

Appendix H

Demographics

How old are you?

____ Under 18

____18-24

____25-34

____35-44

____45-54

____55-64

____65+

What gender do you identify with?

____ Female

____ Male

____ Other: Specify: _____

What is your Ethnicity?

____White or Caucasian

____ Black or African American

____ Hispanic or Latino

____Asian or Asian American

____American Indian or Alaska Native

____Native Hawaiian or other Pacific Islander

____mixed

____Other (please specify)

What is your household income?

____Under $15,000

____ Between $15,000 and $29,999

____ Between $30,000 and $49,999

____ Between $50,000 and $74,999

____ Between $75,000 and $99,999

____Between $100,000 and $150,000

____Over $150,000

Highest level of education obtained?

____ Less than High School

____ High School or GED

____ Associates Degree

____ Some college

____ Bachelor's degree

____ Post-Bachelor's

____ Master's

____ Doctorate

____ Professional

Appendix I

Informed consent

Hello:

You are invited to participate in a survey being conducted by a PSYD student at George Fox University. It will take approximately 10-15 minutes to complete the questionnaire. Your participation in this study is completely voluntary. There are no foreseeable risks associated with this project. However, if you feel uncomfortable answering any questions, you can withdraw from the survey at any point.

Your survey responses will be strictly confidential and data from this research will be reported only in the aggregate. Your information will be coded and will remain confidential. If you have questions at any time about the survey or the procedures, you may contact Javeen Beard at (760) 662-1222 or by email at the email address specified below.

Email: Jbeard18@georgefox.edu

Thank you very much for your time and support. Please start with the survey now by clicking on the **Continue** button below.

Appendix J

“Alexithymia involves deficits in naming and expressing emotions, distinguishing emotions from bodily sensations, and a preference for external rather than internal thinking patterns (Taylor, Bagby, & Parker, 1999).”

Appendix K

JAVEEN BEARD, MA

(760) 662-1222
jbeard18@georgefox.edu

Education

Anticipated July 2023	Doctor of Clinical Psychology George Fox University (APA accredited)
Anticipated February 2023	Dissertation: Relative Impact of Human & Natural Trauma on Psychological Functioning Committee: Rodger Bufford, Ph. D., Kenneth Logan, PsyD., & Aundrea Paxton, PsyD.
May 2020	Master of Arts, Clinical Psychology George Fox University
June 2018	Bachelor of Arts, Psychology California State University- San Bernardino Departmental Honors in Psychology Thesis: *The Relationship Between Early Maladaptive Schemas and Depression: The Mediational Role of Psychological Inflexibility*

Clinical Experience

June 2022-Present — Therapist, Doctoral Intern
VA Southern Nevada healthcare system
Setting: VA Medical System
Major Rotation: Primary Care Mental Health integration (PCMHI)
Supervisor: Ashely Taylor, PhD.
Role:

Perform functional assessments and provide behavioral health consultation to Veterans for numerous issues including but not limited to, depression, anxiety, stress management, and chronic pain. Engage in warm hand-offs and collaborate with physicians, nurses, clinical pharmacists, and other professions to provide comprehensive healthcare to Veterans. Provide psychological screeners and assessments when appropriate including depression, anxiety screeners, and trauma screeners.

Major rotation: Behavioral Health Integration program (BHIP)
Supervisor: Nicole Anders, PsyD
Role:

Perform diagnostic assessments for Veterans. Assesses high risk factors, acuity and need for services. Provide evidenced base psychotherapies (e.g., CBT, CBT-I, EMDR,) in individual and group formats for a wide range of Veterans with mental health needs.

Major Rotation: PTSD Program (Beginning January 2023)
Supervisor: Tricia Steeves, PhD
Role:
Providing Veterans and fellow team members with psychological consultation to support Veteran improvement in quality of life and sustainment of lifestyle changes. Providing comprehensive, evidence-based psychotherapeutic interventions (e.g. PE, CPT, EMDR), including individual, family, and group psychotherapy.

Minor rotation: Assessment
Supervisor: Lisa Duke, PhD.
Role:
Provides neuropsychological and psychological evaluations for Veterans, including administration, scoring, and interpretation of individual tests and batteries of tests. Conduct an extensive review of additional background information that may include, but not be limited to, developmental, educational, occupational, interpersonal, legal, medical, psychiatric and substance abuse histories

Minor rotation: Evidence based protocols (Couples EBP)
Supervisor: Benjamin Loew, PhD.
Role:
Provide evidenced based psychotherapies (e.g., IBCT, CBCT,) for couples.

August 2021-
May 2022

Therapist, Predoctoral Intern
Portland VA Health Care System-Vancouver
Setting: VA Medical System
Supervisor: Kathryn Marshall, Psy.D.
Role:
Counsel individuals to help them understand problems, deal with crisis situations, define goals, and develop realistic action plans. Interact with clients to assist them in gaining insight, defining goals, and planning action to achieve effective personal, social, educational, or vocational development and adjustment. Consult with or provide consultation to other doctors, therapists, or clinicians regarding patient care.

September 2021-
May 2022

Therapist, Part time
Trellis Counseling
Setting: Private practice
Supervisors: Barbara Majors, MSW LCSW & Kristie Schmidlkofer, PsyD

April 2021- Therapist, Full time
August 2021 Cedar Hills Hospital-Outpatient
Setting: Intensive Outpatient
Supervisor: Jory Smith, PsyD.
Role:
Lead the co-occurring program. Counsel clients or patients, in group sessions, to assist in overcoming dependencies, adjusting to life, and making changes. Perform crisis interventions with patients. Develop treatment plans. Assess patients for risk of suicide. Case management.

August 2020- Therapist, Practicum II
March 2021 Cedar Hills Hospital- Military Unit
Setting: Inpatient Hospital
Supervisors: Mario Bolivar, LCSW, Jory Smith, PsyD.
Role:
Interview clients, review records, and confer with other professionals to evaluate individuals' mental and physical condition and to determine their suitability for participation in a specific program. Co-lead chemical dependency groups. Consult with and provide consultation to other doctors, therapists, or clinicians regarding patient care. Identify psychological, emotional, or behavioral issues and diagnose disorders, using information obtained from interviews and tests.

August 2019- Therapist, Practicum I
July 20220 Behavior Health Center
Setting: Mental Health Clinic
Supervisors: Flora Ma, M.A., Joel Gregor, PsyD.
Role:
Provide diagnosis of mental disorders and provide brief evidence-based interventions. Interact with clients to assist them in gaining insight, defining goals, and planning action to achieve effective personal, social, educational, or vocational development and adjustment. Develop and implement individual treatment plans, specifying type, frequency, intensity, and duration of therapy.

October 2018- Facilitator
November 2018 Depression group
Setting: Psychoeducation and Group Counseling
Peer supervisor: Rana Tanios, M.A. Supervisor: Glena Andrews PhD. MSCP, ABPP
Role:
Facilitate discussion with members of the group.

September 2016- Crisis Counselor
June 2018 Crisis Textline

Supervisor: Coe Bethea
Role:
Perform crisis intervention for texters. Assess texters imminent risk for suicide.

Teaching and Academic Experience

June 2021-
April 2022
Graduate Assistant: Clinical Foundations
Doctor of Clinical Psychology**,** George Fox University
Supervisor: Aundrea Paxton, PsyD
Role:
Teaching clinical skills in a small group format and individual supervision. Provide feedback on student psychotherapy interactions. Weekly supervision with students and supervisor. Reviewing videos and progress notes for peer and analogue clients. Summative feedback at the end of each semester.

August 2021-
December 2021
Teaching Assistant: Cognitive Behavioral Therapy
Doctor of Clinical Psychology**,** George Fox University
Supervisor: Danny Rodriguez, PsyD.
Role:
Schedule and maintain regular office hours to meet with students. Evaluate and grade examinations, assignments, or papers and record grades.

August 2020-
December 2020
Teaching Assistant: Cognitive Behavioral Therapy
Doctor of Clinical Psychology**,** George Fox University
Supervisor: Joel Gregor, PsyD.
Role:
Schedule and maintain regular office hours to meet with students. Evaluate and grade examinations, assignments, or papers and record grades.

August 2020-
December 2020
Teaching Assistant: Psychopathology
Doctor of Clinical Psychology, George Fox University
Supervisor: Elizabeth Hamilton, PhD. & Amber Nelson, PsyD.
Role:
Schedule and maintain regular office hours to meet with students. Evaluate and grade examinations, assignments, or papers and record grades.

August 2019-
December 2019
Teaching Assistant: Psychopathology
Doctor of Clinical Psychology**,** George Fox University
Supervisor: Elizabeth Hamilton, PhD.
Role:
Schedule and maintain regular office hours to meet with students. Evaluate and grade examinations, assignments, or papers and record

grades.

September 2019-
November 2019
Depression Group Supervisor
George Fox University
Supervisor: Glena Andrews, PhD., MSCP, ABPP
Role:
Teaching clinical skills in a small group. Provide feedback on student psychotherapy interactions. Provide weekly supervision for students.

November 2019
Guest Lecturer*: Getting into Grad School*
Psychology Honors Course
California State University, San Bernardino
Professor: Kelly Campbell, Ph.D.

October 2018
Guest Lecturer*: Getting into Grad School*
Psychology Honors Course
California State University, San Bernardino
Professor: Kelly Campbell, Ph.D.

Research Experience

February 2021-
Present
George Fox University
Relative Impact of Human & Natural Trauma on Psychological Functioning
Committee: Roger Bufford, PhD., Kenneth Logan, PsyD., & Aundrea Paxton PsyD.
Role:
Produce documentation of the questionnaire development process, data collection methods, sampling designs, and decisions related to sample statistical weighting. Determine and specify details of survey projects, including sources of information, procedures to be used, and the design of survey instruments and materials.

September 2020-
August 2021
George Fox University
The Relationship between Grace and Self-Compassion
Committee Chair: Rodger Bufford, PhD.
Role:
Conduct literature reviews. Recruit participants. Review, classify, and record survey data in preparation for computer analysis.

September 2019-
August 2020
George Fox University
The Relationship between Personality Traits and Self-Compassion
Committee Chair: Roger Bufford, PhD.
Role:
Conduct literature reviews. Recruit participants. Review, classify, and record survey data in preparation for computer analysis.

August 2017- June 2018	California State University-San Bernardino Departmental Honors in Psychology Thesis: *The Relationship Between Early Maladaptive Schemas and Depression: The Mediational Role of Psychological Inflexibility* Advisor: Michael Lewin, PhD. Role: Prepare study-related documentation, such as protocol worksheets, procedural manuals, and institutional review board documents. Code, evaluate, and interpret collected study data. Schedule participants for appointments as required by study protocols.
August 2017- June 2018	California State University- San Bernardino *The Relationship between Early Maladaptive Schemas and Depression: Support and Emotion* Advisor: Michael Lewin, PhD. Role: Develop study protocols, including guidelines for administration or data collection procedures. Prepare tables, graphs, fact sheets, and written reports summarizing research results.
September 2016- June 2017	California State University- San Bernardino Research Assistant Advisor: Jason Reimer, PhD. Role: Screen potential participants to determine their suitability as study participants. Obtain informed consent from research participants or their guardians. Administered and score working memory task for study participants.

Professional Presentations

August 2021	Price, L., Flores, M., Beard, J. L., Bufford, R. (2021). *The Relationship between Grace and Self-Compassion.* Presented at American Psychological Association (APA) conference. San Diego, California.
March 2021	Bufford, R., Beard, J. L., Flore, M., Price, L., & Hodge, A. (2021). *Dimensions of Grace Scale: Concurrent Validation* [Symposium]. Christian Association for Psychological Studies (CAPS) 2021. Virtual Convention, United States.
August 2020	Beard, J. L., Price, L., Flores, M., & Bufford, R. (2020). *The Relationship between Personality Traits and Self-Compassion*. Presented at American Psychological Association (APA) conference. Chicago, Illinois.
May 2018	Beard, J. L., & Lewin. (2018). *The Relationship Between Early Maladaptive Schemas and Depression: The Mediational Role of*

Psychological Inflexibility. Presented at Meeting of the Minds: CSUSB, San Bernardino, California

April 2018 Beard, J. L., & Lewin. (2018). *The Relationship Between Early Maladaptive Schemas and Depression: The Mediational Role of Psychological Inflexibility.* Presented at Western Psychological Association (WPA) conference: Portland, Oregon.

Other Professional Experience

August 2018-
May 2019 Academic Success Coach
George Fox University
Supervisor: Rick Muthiah
Role:
Provide resources for students to aid them in being successful in college.

November 2015-
June 2018 Peer Advisor
Student Success Peer Advising
California State University-San Bernardino
Role:
Help undeclared students with their academic reports. Help undeclared students find classes for the upcoming quarter.

June 2016-
July 2016 Camp Counselor
Super Camp
Loyola Marymount University
Role:
Greet new arrivals to activities, introducing them to other campers, explaining facility rules and encourage participation. Encourage campers to develop their own activities and leadership skills through group discussions.

September 2015-
December 2015 Student Mentor
Student Mentoring Program
California State University-San Bernardino
Role:
Help freshman with their first year of college. Listen to student's problems and find ways to resolve their problems.

January 2015-
June 2015 Student Assistant
Student Success Peer Advising
California State University-San Bernardino
Role:
Answer telephones, direct calls and take messages for undeclared students. Maintain and update filing, inventory, mailing, and database systems, either manually or using a computer. Setup appointments for

undeclared students.

Leadership Experience

September 2020- February 2021	Admissions Committee George Fox University Role: Participate and oversee all aspects of the admissions process. Evaluate applications and participate in the interview process.
September 2019- August 2020	Admissions Committee George Fox University Role: Participate and oversee all aspects of the admissions process. Evaluate applications and participate in the interview process.
June 2019- June 2020	Student Council, Secretary George Fox University Role: Manage and maintain meeting schedules. Take notes during meetings.
October 2018- June 2020	Student Council Cohort Representative George Fox University Role: Act as a liaison between cohorts. Help put on events for the graduate community.
June 2017- June 2018	Academic Officer Kappa Delta Chi Sorority Inc. California State University-San Bernardino Role: Implement academic workshops for the chapter, such as Learning *Styles Workshop* and *Improve your Memory, Improve your Grades.* Monitor study hours and grade checks.
June 2016- June 2017	President Kappa Delta Chi Sorority Inc. California State University-San Bernardino Role: Oversee chapter to ensure adherence to national and school policies. Oversee executive officers.
April 2016 - June 2016	Vice President, Kappa Delta Chi Sorority Inc. California State University-San Bernardino Role: Responsible for overall health and effectiveness of the committees,

determine standing committee chairperson and assign committee membership.

April 2016- June 2017
Social Chair
Kappa Delta Chi Sorority Inc.
California State University-San Bernardino
Role:
Implement internal and external socials with other organizations.

April 2015 - September 2015
Orientation Leader
California State University-San Bernardino
Role:
Assist incoming freshmen and transfer students in their transition to the CSUSB.

October 2014- June 2015
Vice President
Village Counsel
California State University-San Bernardino
Role:
Collaborate with other officers to develop housing programs for residents.

Professional Trainings

August 5-7, 2022
Eye movement desensitization and reprocessing (EMDR)
EMDR Institute
Alicia Avila, LCSW

July 29, 2022
Skills Training in Affective and Interpersonal Regulation (STAIR)
VA Southern Nevada
Nicole Anders, PsyD

February 2, 2022
Practice of handling Intractable Conflict in Forensic Psychology
George Fox University
Wendy Bourg, PhD

February 3, 2021
Embodiment: Personal Reflection
George Fox University
Janelle Kwee, PhD

November 4, 2020
Complex PTSD: Advanced Case Conceptualization, Assessment, and Treatment Approaches in Trauma Populations
George Fox University, Newberg, Oregon
Jason Steward, PhD

October 14, 2020
Examining the Role of Neuropsychology within the Pediatric Cancer

Setting
George Fox University, Newberg, Oregon
Justin B. Lee, PhD

March 18, 2020 Effective Therapy with Underserved and Marginalized People
George Fox University, Newberg, Oregon
Daniel Gatzembidi, PsyD

February 12, 2020 Child Adverse Events to Adults with Substance Use Problems
George Fox University, Newberg, Oregon
Amy Stoeber, PhD

September 25, 2019 Promoting Forgiveness
George Fox University, Newberg, Oregon
Everett Worthington Jr., PhD

March 20, 2019 Foundations of Relationships Therapy-The Gottman Model
George Fox University, Newberg, Oregon
Douglas Marlow, PhD

February 13, 2019 Opportunities in Forensic Psychology
George Fox University, Newberg, Oregon
Diomaris Safi, PsyD and Alex Millkey, PsyD

February 25, 2019 Domestic Violence: A Science Based Approach
George Fox University, Newberg, Oregon
Patricia Warford, PsyD

October 10, 2018 Old Pain in New Brains
George Fox University, Newberg, Oregon
Scott Pengelly, PhD

September 26, 2018 Spiritual Formation and the Life of a Psychologist: Looking Closer at Soul-Care
George Fox University, Newberg, Oregon
Lisa Graham McMinn, PhD and Mark McMinn, PhD

Grants

June 2017-August 2017 California State University-San Bernardino, Office of Student Research Summer Research Fellowship
Cognitive Assessment of Attention and Recall Bias in Sexual Assault Survivors
Advisor: Michael Lewin, PhD.
Role:
Identify protocol problems, inform investigators of problems, or assist In problem resolution efforts, such as protocol revisions. Collaborate with investigators to prepare presentations or reports of clinical study procedures, results, and conclusions.

June 2017-August 2017 California State University-San Bernardino, Office of Student Research Research Fellowship
Behavioral Assessment of Acrophobia: A comparison of Virtual Reality and In-Vivo Assessments
Advisor: Michael Lewin, PhD.
Role:
Review proposed study protocols to evaluate factors such as sample Collection processes, data management plans, or potential subject risks assess eligibility of potential participants through screening methods.

Honors and Awards

Fall 2018-April 2022 Diversity Scholarship Recipient – George Fox University
Fall 2014 Dean's Honors list. California State University-San Bernardino
Spring 2015 Dean's Honors list. California State University-San Bernardino
Fall 2016-Spring 2017 Dean's Honors list. California State University-San Bernardino

Professional Memberships

January 2019-Present American Psychological Association
January 2019-Present Division 19: Society for Military Psychology

Present Certifications

May 2021-Present Trauma Treatment Certified

October 2018-Present American Heart Association Basic Life Support (CPR and AED) program

Appendix A: Relevant Graduate Coursework

Completed coursework
Professional Issues
Pre-internship
Superv & Manag of Psyc Serv I
Dissertation/Research Team
Bio Basis Behavior
Statistics
Neuropsych Assessment Interpretation
Practicum II
Consult, Educ & Prog Eval II
Spiritual Formation
Dissertation/Research
Neuropsych Assessment Foundations

Practicum II
Substance Abuse
Spiritual and Religious Diversity in Health Service Psychology
Selected Topics-Course Topic: Trauma Work Consultation Group
Consult, Educ & Prog Eval I
Spiritual Formation 4
Integrative Topics 2
Multicultural Therapy
Psychodynamic
Research Design
Trauma Treatment in Clinical Practice
Spiritual Formation 3
Research Team - III
Psychodynamic Psychology
Cognitive Assessment
Cognitive Behavioral Therapy
Spiritual Formation II
History & Systems of Psychology
Clinical Foundations I
Psychopathology
Ethics for Psychologists
Lifespan Development
Spiritual Formation I
Theories of Personality/Psychotherapy
Clinical Foundations II
Psychometrics
Personality Assessment
Family Therapy in a Diverse Culture
Learning, Cognition, and Emotion
Social Psychology

Appendix B: Assessment Experience

Screen Tools

Columbia-Suicide Severity Rating Scale (C-SSRS)
Generalized Anxiety Disorder Screener (GAD-7)
MacLean Screening Instrument for BPD
Mini Mental Status Examination, 2nd Edition (MMSE-II)
Patient Health Questionnaire (PHQ-9)
Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)

Personality Assessment

16 Personality Factor Questionnaire
Minnesota Multiphasic Personality Inventory (MMPI-2)
Personality Assessment Inventory (PAI)

Neuropsychology Assessment

Boston Naming Test
California Verbal Learning Test
C-Toni
Dkefs
Grooved Pegboard
Jordan Left-Right Reversal Test, Third Edition (Jordan-3)
Rey complex figure
Wechsler Adult Intelligence Scale- 4th edition (WAIS-IV)
Wechsler Memory Scale- 4th edition (WMS- IV)
Wisconsin card sorting task (WCST)
Test of Memory Malingering

The Woodcock-Johnson Tests of Cognitive Abilities