

1-1-2015

Coping Methods that Predict Reduced Symptoms of Posttraumatic Stress Disorder (PTSD)

Autumn Van Meter

George Fox University, avanmeter@georgefox.edu

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Recommended Citation

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Coping Methods that Predict Reduced Symptoms of Posttraumatic Stress Disorder (PTSD)

by

Autumn Van Meter

Presented to the Faculty of the
Graduate Department of Clinical Psychology
George Fox University
in partial fulfillment
of the requirements for the degree of
Doctor of Psychology
in Clinical Psychology

Newberg, OR

April, 2016

Coping methods the predict reduced symptoms of Posttraumatic Stress Disorder (PTSD) for

People who have experienced a traumatic event

By

Autumn Van Meter, MA

has been approved

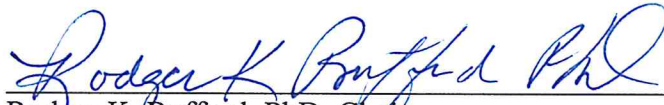
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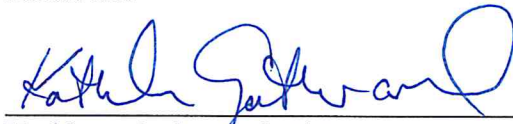
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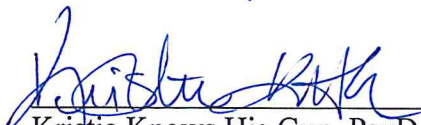
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Signatures:


Rodger K. Bufford, PhD, Chair

Members:


Kathleen Gathercoal, PhD


Kristie Knows His Gun, PsyD

Date: 2-12-16

Coping Methods that Predict Reduced Symptoms of Posttraumatic Stress Disorder (PTSD)

Autumn Van Meter

Graduate Department of Clinical Psychology

George Fox University

Newberg, Oregon

Abstract

Objective: Most individuals experience a stressful event at some point in their lives. A third to half of those individuals will meet criteria for Posttraumatic Stress Disorder (PTSD) during their lifetime. Individuals that do not develop PTSD likely have better coping skills regarding trauma. Targeting specific coping strategies that reduce PTSD symptoms helps mental health professionals and providers create interventions and prevention skills.

Method: Eighty-four participants from a university took an online survey. Demographic information were gathered. Questionnaires were given to determine if the participant had experienced one or more traumatic events. Next, a questionnaire that measured the extent that participants endorsed symptoms of PTSD. Finally, participants completed coping questionnaires looking at different types of coping.

Results: Results found an increase in all coping methods, both positive and negative, when there was an increase in PTSD symptomology. Results also showed higher PTSD symptomology, coping, and higher levels of both positive and negative religious coping for those who provided trauma anecdotes when compared to those who did not. Women endorsed more positive coping, religious coping and positive religious coping than men. About half of the variance in traumatic experiences was accounted for by TLEQ, ACE, and Negative Coping.

Conclusions: Individuals are more likely to engage in all types of coping when experiencing PTSD symptomology. Individuals who provided anecdotal information about trauma tended to show more distress and coping efforts compared to those who do not. Finally, women were more prone to report increased use of coping methods.

Key words: Posttraumatic Stress Disorder, trauma, religious coping, positive coping, negative coping

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Chapter 1

Introduction

According to Kessler, Chiu, Demler, and Walters (2005), 74% of women and 81% of men will experience what qualifies as a stressful event in their lifetimes. However, according to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5*; American Psychiatric Association [APA], 2013) only 30-50% of those who have experienced a traumatic event will meet criteria for a diagnosis for Posttraumatic Stress Disorder (PTSD) at some point in their lives. The *DSM-5* (APA, 2013) also indicates that there is an 8.7% lifetime risk rate for adults in the United States, suggesting as many as 25 million in the US may experience PTSD during their lifetimes. What is the difference between those who develop PTSD and those who do not? Chapman et al.'s (2012) research also shows a projected lifetime remission rate of 92% for those suffering from PTSD. This high remission percentage shows that most of those with PTSD will at some point have a remission of their symptoms. There are also a number of temperamental, environmental, and genetic or physiological pretraumatic factors that are risk or protective factors for those who experience traumatic events. Those data raise another question as to what strategies or coping methods those individuals are using that are effective at preventing or decreasing PTSD symptoms after a traumatic event.

PTSD predicts a number of different life impeding symptoms. Poorer problem solving skills (Kasckow et al., 2012), increased hostility (McHugh, Forbes, Bates, Hopwood, & Creamer, 2012), poorer physical health (Galor, & Hentschel, 2012), lower levels of self-efficacy and increased alcohol and drug abuse have all been associated with PTSD (Read, Colder, Merrill,

Ouimette, White, & Swartout, 2012). The DSM-5 (APA, 2013) also indicates that those with PTSD experience impaired functioning exhibited across social, interpersonal, developmental, educational, physical health, and occupational domains and has been supported by research (McCaslin et al., 2016). The large amount of negative symptoms and functional impairment should elicit concern among mental health professionals. Finding information regarding how those who have experienced traumatic event or events cope is essential in creating better interventions and skills for prevention.

In 1998, Felitti et al. conducted the initial Adverse Childhood Experiences (ACE) study which helped lay ground work for future research in comparing how adverse childhood experiences influence adult diseases. A basic search using ACE as the topic on EBSCOhost (an online research database including more than 375 full-text secondary research databases) shows over 2,500 related research article to ACE's. Originally Felitti et al. (1998) researched the effects ACE had on risk factors for the leading causes of death in adult life but further research has led to other discoveries about the influences of adverse childhood experiences. Those who have experienced ACEs utilize health care more (Chartier, Walker, & Naimark, 2010), are more likely to develop PTSD (Kaess et al., 2012), and have poor adult health care (Stringe et al., 2012), increased nonsuicidal self-injury, and higher rates of psychological distress and adult alcohol problems (Walling, Eriksson, Putman, & Foy, 2011). Felitti et al. (1998) discovered that 52.1% of the population had experienced at least one ACE. Childhood trauma has also been linked a number of clinical indicators such as internalizing and externalizing problems such as depression, Generalized Anxiety Disorder (GAD), Seasonal Affective Disorder (SAD), attachment problems, behavioral problems, self-injury, criminal activity, dissociative symptoms and PTSD (Spinazzola et al., 2014).

A number of different risk factors are influential for whether an individual develops PTSD after a traumatic event. Some of the key risk factors include prior exposure to traumatic events, traumatic event severity, comorbidity of other psychological disorders, age, and gender (Bomyea, Risbrough, & Lang, 2012; Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012). Environmental factors, such as social environment, have also shown to be factors involved in the development of PTSD (Breslau, Wilcox, Storr, Lucia, & Anthony, 2004) as well as psychological factors such as shame and guilt (Pugh, Taylor, & Berry, 2015). PTSD has also been linked to intergenerational effects, suggesting that children with parents who have developed PTSD or experienced traumatic events are more likely than those without this family history to develop PTSD or experience a traumatic event (Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012). This finding supports the notion of generational trauma seen within research on Holocaust survivors (Doucet & Rovers, 2010; Jacobs, 2011) and such as reported among Native Americans (Heart, Yellow Horse, & Deschenie, 2006).

A few coping methods have been shown to be more effective and others less effective at reducing symptoms of PTSD. Overall, it has been found that avoidant coping is related to an increase of PTSD symptoms and less effective treatment response rates (Badour, Blonigen, Boden, Feldner, & Bonn-Miller, 2012; Hassija, Luterek, Naragon-Gainey, Moore, & Simpson, 2012). Hobfoll et al. (1991) argue that there are a number of different positive and negative coping strategies for those suffering from PTSD. They note social support, seeking help, breaking down problems into more manageable subcomponents, and self problem solving as types of good coping for those with PTSD. The more internal resources the individual has to seek and find external resources the better the individual will cope. Hobfoll et al. (1991) reported that coping styles that have negative effects include excessive self-blame, prolonged avoidance,

blaming/lashing out at others, drugs and alcohol use/abuse, cynicism, excessive pessimism (low expectations), and social isolation. Research conducted on college students found that after individuals had experienced complicated grief surrounding a traumatic loss, found that problem-focused and active and avoidant emotional coping styles were positively correlated with PTSD severity and complicated grief (Schnider, Elhai & Gray, 2007).

Religious coping is a body of research that has been steadily growing over the last decade and a half (Pargament, Feuille, & Burdzy, 2011). Pargament, Smith, Koenig, & Perez (1998) found a pattern of religious coping that was positive for those who had experienced traumatic events. Those positive religious coping strategies included: seeking spiritual support, religious forgiveness, collaborative religious coping, spiritual connection, religious purification, benevolent religious reappraisal, and religious focuses. Pargament et al. (1998) also found negative religious coping that included: spiritual discontent, punishing God reappraisals, interpersonal religious discontent, demonic reappraisal, and reappraisal of God's powers.

This study is designed to identify the coping styles that predict lower amounts of reported PTSD symptoms among those who have experienced one or more traumatic events. This idea is predicated on the fact that not everyone who experiences a traumatic event will meet criteria for PTSD.

Emotional coping, utilizing internal resources, and seeking external resources have been shown to be a more effective coping method for PTSD, and avoidance coping has been found to be a less effective coping method. Thus, I predict that coping methods that are more engaging with PTSD (e.g., active coping, use of emotional support, use of instrumental support, venting, positive reframe, humor, and accepting will predict lower symptoms of PTSD, while coping methods that are less engaging (e.g., self-distraction, denial, substance use, behavioral

disengagement, and self-blame) will predict more PTSD symptoms. Similarly, religious coping that has been associated with positive religious coping (e.g., seeking spiritual support, spiritual connection, collaborative religious coping) will predict lower symptoms of PTSD, while religious coping that has been associated with negative religious coping (e.g. spiritual discontent, punishing God reappraisals, demonic reappraisal) will predict more PTSD symptoms.

Chapter 2

Methods

Participants

Participants included 84 students recruited from a private university located on the West Coast. Participants were granted research credits for an introductory psychology course. While four participants did not press “continue” on the first page of the survey that indicated consent, they were included in the survey because they completed it. Completion of the survey was considered consent (see Appendix A). Among participants, 60.7% of participants identified as Female, 36.9% as Male, and 2.4% of participants as Transgender. Their mean age was 18.8 (SD=1.1). The majority of students identified themselves as Caucasian (76.2%), the remainder included 10.7% who identified as Asian/Pacific Islander, 7.1% as Hispanic/Latino, 4.8% African-American and 1.2% Native American. The majority of participants were freshman (61.9%), with the additional 20.2% being sophomores, 8.3% juniors, and 9.5% seniors. Among participants 86.9% reported being from the western region of the United States, with 4.8% identifying with the central region, 2.4% northeast, 2.4% southern, and 3.6% outside of the USA. For Household Income, 21.4% of participants identified their families having an estimated annual income of \$100,000 a year or more.

Researcher analyzed data using descriptive statistics, correlations, t-tests, and analyses of variance. Descriptive statistics were computed for all of the scales there were included in the study. Correlational statistics were computed determining the relationships between scales.

Group comparisons were also conducted, looking at differences between gender, anecdotal information, and levels of PTSD symptomology.

Instruments/Materials

Six different measures were used in this study. Instruments will be used to gather data information include: demographics questionnaire, ACE, two traumatic experiences, PTSD symptomology, religious coping, and non-religious coping.

Demographic information. Information in regards to gender, race, marital status, geographic location, age, socioeconomic status, religious affiliation, and year in school was gathered. This was gathered through the survey in multiple-choice format with the option for other if they do not fit into a given category. See Appendix B.

Adverse Childhood Experiences, Felitti et al., 1998. The Adverse Childhood Experiences (ACE; Felitti et al, 1998) is a survey about adverse childhood experiences. It includes ten different categories of possible adverse experiences. These include psychological, physical, or sexual abuse, violence against mother, living with household members who were substance abusers, mentally ill, or ever imprisoned. Each category has questions associated with it on the survey for a total of 10 questions. Options for *yes* or *no* are given on the survey. If a participant responds with a *yes* they are added to that category of experiencing an Adverse Childhood Experience. The test-retest reliability statistics from the ACE study show good to excellent reliability in reports during adulthood (Dube, Williamson, Thompson, Felitti, & Anda, 2004). Researcher found alpha coefficient .61 for the ACE. See Appendix F.

Trauma History Screen, Carlson et al., 2009. A survey about encounters with traumatic events will also be administered. The Trauma History Screen (THS) includes 11 events including military trauma, sexual assault and natural disasters. It has 13 items with *yes* or *no* as

possible responses. For the items endorsed additional questions are included, asking the age at time of event, description of event, threat of death or injury, feelings of helplessness, feelings of dissociation, distress level, and duration of stress. The Kappa reliability for the THS ranges from good to excellent (Carlson et al., 2011). Researcher found alpha coefficient .69 for the THS. See Appendix H.

Traumatic Life Events Questionnaire, Kubany et al., 2000. The Traumatic Life Events Questionnaire (TLEQ) is a self-report scale that assesses exposure to traumatic events. It includes 21 types of potentially traumatic events (*yes* or *no* response) and includes questions to determine if the individual experienced fear, helplessness or horror when they were exposed to the traumatic event. The survey also includes a section for the respondent to give a response description of trauma and asks which event they perceive as the worst. The test-retest reliability for the TLEQ averaged 83% (Norris & Hamblen, 2004) and convergent validity found Kappa coefficients to be between .40 and .60 (Orsillo, 2001). Researchers found alpha coefficient .64 for the TLEQ. See Appendix C.

Distressing Events Questionnaire, Kubany et al., 2000. The Distressing Events Questionnaire (DEQ) measures *DSM-IV* (APA, 1994) criteria for PTSD. It has four different parts and has 38 items on the survey. Each of the four different parts is associated with a particular criterion described in the *DSM-IV*. The survey has been used to make a preliminary diagnosis of PTSD using a cutoff score of 17. The Cohen's alpha coefficient for the DEQ is .93 and the DEQ has a .83 correlation with the Penn Inventory (another diagnostic tool used to diagnose PTSD) suggesting a strong reliability and validity for this measure (Kubany, Leisen, Kaplan, & Kelly, 2000). Researchers found alpha coefficient .95 of the DEQ. See Appendix D.

Brief Religious Cope, Pargament et al., 1998. The Brief Religious Cope (Brief RCOPE) looks at to what extent religion plays a role in coping. It has 14 different questions looking at ways of coping, both negative and positive. The respondents answer on a 4-point Likert scale. There is no reverse scoring, as participants endorse the extent in which they are engaging in each coping method. The R-COPE is designed to include five different religious functions: meaning, control, comfort intimacy, life transformation, and the search for the sacred or spirituality itself (Pargament et al., 2011). Research has confirmed high reliability ($\alpha = .80$) on the Brief R-COPE (Pargament et al., 2011). Researchers found alpha coefficient .94 for the R-COPE. See Appendix E.

Brief Cope, Carver, 1997. The Brief Cope is a shortened version of the COPE. This is a 28-item scale that looks at 14 different ways that individuals cope with stressful events in their lives. These include self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioral disengagement, venting, positive reframing, planning, humor, acceptance, religion and self-blame (Carver, 1997).

The respondents will answer on a 4-point Likert scale ranging from *not at all* to *a lot*. There is not reverse scoring. The Brief COPE has a reliability range from .50-.90 with only acceptance (.57), denial (.54), and venting (.50) that fall under the .60 (Carver, 1997). In addition to reliability the Brief Cope has been compared to the factorial structure of the original Cope by an exploratory factor analysis. The results yielded a factor structure that was generally consistent with the full Cope, suggesting a strong level of validity (Carver, 1997). Researchers found alpha coefficient .94 for the Brief COPE. See Appendix G.

Procedure

A survey was sent out that had been created through an Internet survey engine. The survey was presented to participants through the psychology department at the university after receiving Institutional Review Board (IRB) approval. The survey included all of the instruments listed above as well as specific questions used to ascertain certain demographic information. The Internet survey engine gathered and organized the data. The data was then transformed into IBM Statistical Analysis Software Package (SPSS) where the researcher was able to analyze the results.

First, demographic information was gathered pertaining to each participant. Secondly, the ACE, the TLEQ and the THS questionnaires will be used to determine if the participant has experienced one or more traumatic events. Next, the DEQ questionnaire will determine to what extent the participant is endorsing symptoms of PTSD. The participant will then fill out the Brief R-COPE and the Brief COPE designed to measure the different types of coping methods being used by each participant.

Chapter 3

Results

Descriptive Statistics

Descriptive statistics, including internal consistencies, mean, standard deviation, skew and kurtosis were computed for each measure. The three measurement scales for previously experienced traumatic events (TLEQ, THS, ACE) all received Cronbach's Alpha scores between .60 and .70. These three internal consistency scores likely represent the independent nature of experiencing traumatic events, given that they can occur exclusively from each other. See Table 1.

Table 1

Descriptive Statistics

	Cronbach's Alpha	Mean	Standard Deviation	Skew	Kurtosis
TLEQ	.64	49.04	2.40	1.2	2.49
THS	.69	17.59	1.48	1.34	3.53
ACE	.61	14.13	1.47	1.23	.77
DEQ	.95	54.54	16.49	.71	.04
BriefCOPE	.94	77.96	18.68	-.65	.19
BriefRCOPE	.94	41.78	9.82	-.87	1.12
PosCope	.95	54.58	14.4	-.45	-.19
NegCope	.86	26.89	6.06	-.48	.57
PosRelCope	.95	25.01	7.47	-.66	-.44
NegRelCope	.89	16.77	4.58	.85	1.63

Internal consistency, Cronbach's Alpha, for PTSD symptomology (DEQ) was .95, suggesting high internal consistency. Additionally, all coping scales had internal consistency above .80 suggesting a strong relationship among the items in the coping scales.

The TLEQ, THS, ACE and DEQ were positively skewed. The TLEQ and the THS also have a high kurtosis. This information will be helpful in interpretation of the results, as the correlations will likely be underestimations of the relationship.

Correlations

Correlations among scales were computed. Results showed that the three trauma scales were all significantly and positively correlated with each other. The THS and TLEQ were the most strongly correlated with one another ($r = .737, p < .01$). Though, still significant the ACE scale was less strongly correlated with the THS ($r = .409, p < .01$) and TLEQ ($r = .383, p < .01$). Because the THS and the TLEQ look specifically at traumas that an individual might encounter, while the ACE scale categorizes adverse experiences an individual has in childhood, this likely accounts for the stronger relationship between the THS and TLEQ and the weaker relationship between those two scales and the ACE.

The correlational statistics for the DEQ (PTSD symptomology) and the trauma scales also all showed significant positive relations. As the number of items on the trauma scales increased, so did the PTSD symptomology. Specifically the TLEQ had the strongest correlation with the DEQ ($r = .564, p < .01$), followed with the THS ($r = .500, p < .01$) and then the ACE ($r = .436, p < .01$). Similar to the reasoning for why the ACE did not correlate as highly to the THS and TLEQ, due to the nature of the structure of the ACE, it would appear to make sense that the THS and TLEQ were more highly positively correlated with the DEQ.

Lastly, the correlational statistics showed positive correlations between PTSD symptomology and all six of the coping scales. As PTSD symptomology increased coping also increased, regardless of whether it was positive or negative. Both general coping ($r = .547, p < .01$) and religious coping were positively correlated ($r = .386, p < .01$) with PTSD symptomology. Finally, positive coping ($r = .482, p < .01$) and negative coping ($r = .560, p < .01$) were positively correlated with PTSD symptomology. Both positive religious coping ($r = .273, p < .05$) and negative religious coping ($r = .381, p < .01$) were positively correlated with PTSD symptomology. See Table 2.

T-test

A comparison of means found that women reported engaging in significantly more positive coping [$t_{(69.94)} = 2.24, p < .05$], significantly more religious coping [$t_{(62.83)} = 2.40, p < .05$], and significantly more positive religious coping [$t_{(63.88)} = 3.00, p < .01$] than men in this sample. Despite the differences in coping, there were no statistically significant differences found between genders based on the mean of traumatic events experienced (ACE $t_{(75.18)} = 1.50, p = .14$, THS $t_{(64.40)} = 1.03, p = .30$, TLEQ $t_{(70.28)} = 1.25, p = .22$), or the mean amount of PTSD symptomology experienced $t_{(78.31)} = 1.75, p = .08$. See Table 3.

Participants were prompted to provide anecdotal information based on the traumatic experiences that they had experienced. Of the sample, 57.1% of the participants gave anecdotal information. Individuals who reported anecdotal information scored significantly higher on PTSD symptomology [$t_{(75.84)} = -4.22, p < .01$], scored significantly higher in religious coping [$t_{(58.73)} = -2.01, p = .05$], and scored significantly higher in negative religious coping [$t_{(77.75)} = -2.02, p < .05$] than those who did not provide anecdotal information.

Table 2

Scale Correlations

Scale	ACE	THS	TLEQ	DEQ	BCOPE	RCOPE	Positive Coping	Negative Coping	Positive Religious Coping
THS	.409**								
TLEQ	.382**	.737**							
DEQ	.436**	.500**	.564**						
BCOPE	.353**	.310**	.327**	.547**					
RCOPE	.278*	.204	.208	.386**	.713**				
Positive Coping	.304**	.287**	.281**	.482**	.977**	.691**			
Negative Coping	.381**	.317**	.372**	.560**	.933**	.681**	.851**		
Positive Religious Coping	.161	.184	.184	.273*	.616**	.895**	.641**	.534**	
Negative Religious Coping	.334**	.137	.137	.381**	.524**	.685**	.435**	.591**	.288**

** Correlation is significant at the .01 level

* Correlation is significant at the .05 level

Table 3

T-tests

Scale	Gender		Anecdotal		Man Made/Natural	
	T score	Significance	T score	Significance	T score	Significance
ACE	1.50	.14	-1.66	.10	.58	.56
THS	1.04	.30	-4.23	<.01**	.63	.53
TLEQ	1.25	.22	-2.46	.02	-.22	.83
DEQ	1.75	.08	-4.22	<.01**	.62	.54
BCOPE	1.95	.06	-1.90	.06	.83	.41
RCOPE	2.40	.02*	-2.001	.05*	1.02	.32
Positive Coping	2.24	.03*	-1.85	.07	.69	.49
Negative Coping	1.00	.32	-1.54	.13	1.06	.30
Positive Religious Coping	3.00	.00**	-1.47	.15	-.08	.94
Negative Religious Coping	4.00	.69	-2.02	.05*	1.89	.07

** Significant at the .01 level

* Significant at the .05 level

Anecdotal data was categorized into two different categories of kinds of trauma. The first was man made trauma and the second was natural trauma. A *t*-test analysis was computed to determine if there were significant differences between the two types of trauma. Results failed to show any significant differences (DEQ $t_{(45.96)} = .62, p = .54$, BCOPE $t_{(45.90)} = .83, p = .41$, RCOPE $t_{(45.98)} = 1.02, p = .32$, Positive Coping $t_{(45.91)} = .69, p = .49$, Negative Coping $t_{(45.89)} = 1.06, p = .30$, Positive Religious Coping $t_{(42.01)} = -.08, p = .94$, Negative Religious Coping $t_{(45.10)} = 1.89, p = .07$).

ANOVA

A median split was performed on the DEQ (PTSD symptomology) scale to further explore the relationship between traumatic events and levels of PTSD symptomology. Analyses of variance showed that those with higher levels of PTSD symptomology also showed higher levels of traumatic events in all three scales for traumatic events (TLEQ $F(1,82) = 35.51, p < .01$, ACE $F(1,82) = 20.55, p < .01$, THS $F(1,82) = 34.33, p < .01$). ANOVA also showed that higher levels of PTSD symptomology were associated higher levels of coping for all scales of coping methods Brief COPE $F(1,82) = 25.62, p < .01$, RCOPE $F(1,82) = 10.45, p < .01$, Negative Coping $F(1,82) = 20.84, p < .01$, Positive Coping $F(1,82) = 21.94, p < .01$, Positive Religious Coping $F(1,82) = 7.36, p < .01$, Negative Religious Coping $F(1,82) = 5.59, p < .05$.

Table 4

Analyses of Variance

Scale	Median Split DEQ	
	<i>F</i>	Sig
ACE	20.55	.00**
THS	34.33	.00**
TLEQ	35.51	.00**
BCOPE	25.62	.00**
RCOPE	10.45	.00**
Positive Coping	21.94	.00**
Negative Coping	20.84	.00**
Positive Religious Coping	7.36	.01**
Negative Religious Coping	5.59	.02*

** Significant at the .01 level

* Significant at the .05 level

Regression

A stepwise linear regression was computed to assess the role of traumatic experiences and coping in predicting the current degree of trauma in participants. Analysis was completed in two stages: first, traumatic experiences as measured by the TLEQ, THS, and ACE were entered in a step-wise fashion; in a second stage the four coping measures, Brief Cope Positive, Brief Cope Negative, R-COPE Positive, and R-COPE Negative were entered in a step-wise fashion. See Table 5.

TLEQ ($R = .564$; $R^2 = .319$; $\Delta R^2 = .319$; $p < .001$) and ACE ($R = .613$; $R^2 = .376$; $\Delta R^2 = .057$; $p < .008$) entered in the first stage; only Negative Coping ($R = .693$; $R^2 = .480$; $\Delta R^2 = .105$; $p < .001$) entered in the second stage. Together, these account for about half the variance in DEQ scores.

Table 5

Stepwise Regression

Predictors	R	R Square	Adjusted R Square	Df	Sig. F Change
TLEQ	.56	.32	.31	82	>.001
ACE	.61	.38	.36	81	>.01
Negative Coping	.69	.48	.46	80	>.001

Chapter 4

Discussion

Summary of Findings

The expected results were to find an increase in PTSD symptomology associated with negative or avoidant coping as it has been shown in previous research (Badour et al., 2012; Hassija et al., 2012; Schnider et al., 2007). Interestingly, results did not show a specific kind of coping method that was related to lower symptoms of PTSD. The results indicate that when an individual from this sample is experiencing PTSD symptomology there is an increase in coping in general, regardless of the negative or positive aspects of it. While the results show those increases of PTSD symptomology associated with increases of negative coping, there is no indication of reduced symptoms for those who engage in positive coping, and in fact actually shows the opposite.

Differences in gender show that women engage in more positive coping, more religious coping, and significantly more positive religious coping than men. Despite the differences in coping, there were no statistically significant differences found between genders based on the mean number of traumatic events experienced, or the mean amount of PTSD symptomology experienced. These results were surprising, given that previous research suggests that men experience more traumatic events (Kessler et al., 2005) and that women experience more symptoms of PTSD (Bomyea, Risbrough, & Lang, 2012; Trickey et al., 2012). Additionally, results also indicate that about half of the variance in traumatic symptoms (as indicated by the DEQ) within the present sample is accounted for by TLEQ, ACE, and Negative Coping. None of

the other measures contributed significant additional variance. This suggests that negative coping is the most significant form of coping in terms of effects on PTSD symptomology.

Participants who provided anecdotal information showed to differ from those who did not. Those who provided anecdotal information scored significantly higher on PTSD symptomology, scored significantly higher in religious coping, and scored significantly higher in negative religious coping than those who did not provide anecdotal information.

Anecdotal information was coded by the examiner into two different categories: man-made and naturally occurring. Results failed to show a difference for those two groups in PTSD symptomology or coping. This is parallel with results found by Merrell, Bufford, Seegobin, Gathercoal, & Rhoades (2013), where clear differences in the kind of trauma were reported, but results did not find a difference in reported distress.

Limitations

There are several limitations to this study. First, there are limitations to the generalizability of the sample. It was a convenience sample taken from a university setting, of students participating in course credit. The sample was predominantly Caucasian, almost exclusively Christian (95.2%), relatively affluent, and was predominantly from the West Coast region, which is not representative of the general population. Given that the sample was a college sample, predominantly Caucasian, and relatively affluent it is also possible that the samples exposure to traumatic events, PTSD symptomology, and use of coping methods is different than that of the general populations.

Age may have also played a factor in the exposure traumatic events. As an individual ages, the likelihood that they will have experienced some sort of traumatic event increased. The

mean age was 18.8 ($SD = 1.1$). A sample with a higher age will likely have resulted in a higher mean of traumatic events. Age may also play a factor into expression of PTSD symptomology as well as the possibility of the use of difference coping methods.

Another limitation was a lack of assessment for current functioning. While there was a measure of PTSD symptomology, the researcher had absolutely no way of determining how the sample was functioning in their daily lives. For example, an individual may be experience traumatic nightmares, but still get up and go to work or school the next day regardless.

Conclusions

Trauma, PTSD symptomology, and different coping methods were discussed. Results showed an increase in all coping methods with an increase of PTSD symptomology, differences between people who are willing to provide anecdotal information and differences between genders in the use of coping methods. Implications for clinical work include the idea that individuals are likely to engage in all types of coping when experiencing PTSD symptomology regardless of the kinds of coping. The differences between genders, the willingness to provide anecdotal information, and negative coping being most predictive of PTSD symptomology also provides information to clinicians as to what they might expect from those who are exposed to a traumatic event.

Further research should be conducted to look at the differences between the expression of PTSD symptomology and the functioning of an individual. Additional research may also provide insight into how the use of coping methods influences the functioning of an individual who is also experiencing PTSD symptomology.

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Appendix A

Informed Consent

In clicking the continue button I am agreeing to take this survey about trauma. I will complete a survey, which will take about 30-40 minutes to complete.

The survey will include a number of different questions about trauma and coping. Some of the questions I am asked may negatively affect my mood. I understand that I do not have to answer every question that the survey asks me. I understand that if at any time during the study I begin to feel uncomfortable and do not wish to continue I can end my participation.

Other survey questions will ask for some demographic information (e.g., age, marital status, education level) so that we can accurately describe the general traits of the group of individuals who participate in the study.

I understand the information about my participation in this study. All my questions have been answered. I consent to participate in the research described above.

In clicking the continue button I am indicating that I am 18 years of age or older and can provide my consent. I understand that the researcher can answer any questions I have about this study. I understand that I may contact Autumn Van Meter avanmeter07@georgefox.edu or Dr. Rodger Bufford rbufford@georgefox.edu if I have other questions or concerns about this research.

Appendix B**Demographics Questionnaire**

1. What is your current age in years?

_____ Years

2. Gender:

_____ Male

_____ Female

3. Marital Status

_____ Single

_____ Married

_____ Long-term committed relationship

_____ Divorced

4. Ethnic Background

_____ Asian/Pacific Islander

_____ African-American

_____ Caucasian

_____ Hispanic

_____ Native American

_____ Other (list) _____

5. Current College Class

_____ Freshman

_____ Sophomore

_____ Junior

_____ Senior

_____ Graduate

6. Religious Affiliation

_____ Agnostic

_____ Atheist

_____ Buddhist

_____ Christian

_____ Hindu

_____ Islamic

_____ Jewish

_____ Not Affiliated/None

_____ Other (list) _____

7. Annual Household Income

- ☐ Over \$100,000
- ☐ \$75,000 - \$99,999
- ☐ \$50,000 - \$74,999
- ☐ \$40,000 - \$49,999
- ☐ \$30,000 - \$39,999
- ☐ \$20,000 - \$29,999
- ☐ \$10,000 - \$19,999
- ☐ Under \$10,000

8. Geographical Region Most Identified with in USA

- ☐ Central Region
- ☐ Northeast Region
- ☐ Southern Region
- ☐ Western Region
- ☐ Outside USA

Appendix C

Traumatic Life Events Questionnaire

The purpose of this questionnaire is to identify important life experiences that can affect a person's emotional well-being or later quality of life. The events listed below are far more common than many people realize. Please read each question carefully and mark the answers that best describe your experience.

1. **Have you ever experienced a natural disaster (a flood, hurricane, earthquake, etc.)?**
Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no
2. **Were you involved in a motor vehicle accident for which you received medical attention or that badly injured or killed someone?** Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no
3. **Have you been involved in any other kind of accident where you or someone else was badly hurt?** (examples: a plane crash, a drowning or near drowning, an electrical or machinery accident, an explosion, home fire, chemical leak, overexposure to radiation or toxic chemicals) Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no
4. **Have you lived, worked, or had military service in a war zone?** Yes / No
If yes, were you ever exposed to warfare or combat? (for example: in the vicinity of a rocket attack or people being fired upon; seeing someone get wounded or killed) Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no
5. **Have you experienced the sudden and unexpected death of a close friend or loved one?**
Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no
6. **Has a loved one ever survived a life threatening or permanently disabling accident, assault, or illness?** (examples: spinal cord injury, rape, cancer, serious heart condition, life threatening virus) Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no

7. **Have you ever had a life threatening illness?** Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no
8. **Have you been robbed or been present during a robbery where the robber(s) used or displayed a weapon?** Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no
9. **Have you ever been hit or beaten up and badly hurt by a stranger or by someone you didn't know very well?** Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no
10. **Have you seen a stranger (or someone didn't know very well) attack or beat up someone and seriously injure or kill them?** Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no
11. **Has anyone threatened to kill you or cause you serious physical harm?** Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no
12. While growing up: **Were you physically punished in a way that resulted in bruises, burns, cuts, or broken bones?** Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no
13. While growing up: **Did you see or hear family violence?** (such as your father hitting your mother; or any family member beating up or inflicting bruises, burns or cuts on another family member) Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no
14. **Have you ever been slapped, punched, kicked, beaten up, or otherwise physically hurt by your spouse (or former spouse), a boyfriend/girlfriend, or some other intimate partner?** Yes / No
If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no
15. **Before your 13th birthday: Did anyone--who was at least 5 years older than you-- touch or fondle your body in a sexual way or make you touch or fondle their body in a sexual way?** Yes / No

If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no

16. Before your 13th birthday: **Did anyone touch sexual parts of your body or make you touch sexual parts of their body--against your will or without your consent?** Yes / No

If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no

17. After your 13th birthday and before your 18th birthday: **Did anyone touch sexual parts of your body or make you touch sexual parts of their body--against your will or without your consent?** Yes / No

If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no

18. After your 18th birthday: **Did anyone touch sexual parts of your body or make you touch sexual parts of their body--against your will or without your consent?** Yes / No

If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no

19. **Were you ever subjected to uninvited or unwanted sexual attention? (other than sexual contact covered by items 15, 16, 17, or 18) (examples: touching, cornering, pressure for sexual favors, verbal remarks)** Yes / No

If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no

20. **Has anyone stalked you--in other words: followed you or kept track of your activities--causing you to feel intimidated or concerned for your safety?** Yes / No

If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no

21. **Have you or a romantic partner ever had a miscarriage?** Yes / No

If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no

22. **Have you or a romantic partner ever had an abortion?** Yes / No

If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no

23. **Have you experienced (or seen) any other events that were life threatening, caused serious injury, or were highly disturbing or distressing?** (examples: lost in the wilderness; a serious animal bite; violent death of a pet; being kidnapped or held hostage; seeing a mutilated body or body parts) Yes / No

Please describe _____

If this happened: Did you experience intense fear, helplessness, or horror when it happened? yes / no

24. **The events listed below correspond to items #1 to #23 on this questionnaire. If any of these events happened to you, CIRCLE the number of the ONE event (only 1) that CAUSES YOU THE MOST DISTRESS?**

1. Natural disaster	9. Assaulted by acquaintance/stranger	17. As a teen: unwanted sexual contact
2. Motor vehicle accident	10. Witnessed severe assault to acquaintance/stranger	18. As an adult: unwanted sexual contact
3. "Other" kind of accident	11. Threatened with death/serious harm	19. Sexual harassment
4. Combat or warfare	12. Growing up: witnessed family violence	20. Stalked
5. Sudden death friend/loved one	13. Growing up: physically punished	21. Miscarriage
6. Life-threatening/disabling event to loved one	14. Physically hurt by intimate partner	22. Abortion
7. Life threatening illness	15. Before 13: sexual contact-- someone 5 years older	23. Some "other" traumatic event
8. Robbery/weapon used	16. Before 13: unwanted sexual contact	24. None of these events happened to me

Appendix D

Distressing Event Questionnaire

The purpose of this questionnaire is to evaluate your response to the event (or series of events) **experienced by you and noted on the previous page as causing you the most distress** (item 24). (If you did not experience any of the events listed on the last questionnaire (or are not distressed about any of them now), the purpose of this questionnaire is to evaluate your response to the worst or most distressing event you ever did experience.) **Briefly describe what**

Items 1 to 20 ask about the degree to which you experienced 20 symptoms in the **PAST MONTH (the LAST 30 DAYS, COUNTING TODAY)**.

0 = Absent or Did Not Occur

1 = Present to a Slight Degree

2 = Present to a

3 = Present to a Considerable Degree

4 = Present to an Extreme or Severe Degree

1. ____ Unwanted thoughts or mental pictures of the event(s) when nothing was happening to remind you?
2. ____ Bad dreams or nightmares about the event(s)?
3. ____ Suddenly reliving the event(s), flashbacks of the event(s), or acting or feeling as if it was actually happening again?
4. ____ Distress or emotional upset when reminded of the event(s)?
5. ____ Physical reactions when reminded of the event(s)? (such as sweaty palms, rapid breathing, pounding heart, dry mouth, nervous stomach, tense muscles)
6. ____ Efforts to avoid thoughts, conversations, or feelings that would remind you of the event(s)?
7. ____ Efforts to avoid activities, people, or places that would remind you of the event(s)?
8. ____ Unable to remember any important parts of what happened?
9. ____ Loss of interest in activities that had been important--such as loss of interest in your job, hobbies, sports, or social activities?
- 10 ____ Feeling detached or cut off from others around you?

11. ____ Feeling emotionally “numb?” (for example, unable to feel tenderness, loving feelings, joyful feelings, or unable to cry)
12. ____ Thinking your future would be cut short in some way? (for example, no expectation of a career, marriage or children; expecting a shortened life or premature death)
13. ____ Trouble falling or staying asleep?
14. ____ Irritability or outbursts of anger?
15. ____ Difficulty concentrating?
16. ____ Being alert, watchful, or “on guard?”(for example, looking around you, checking out noises, checking to see if windows and doors were locked)
17. ____ Jumpy or startled by sudden sounds or movements?
18. ____ Feeling guilt that was related to the event(s)--in other words, upset because you think you should have thought, felt, or acted differently?
19. ____ Feeling anger that was related to the event(s)--in other words, upset because you think someone else should have thought, felt, or acted differently?
20. ____ Grief, sorrow, or feelings of loss? (over loss of loved ones, belongings, identity, self-worth, faith in human nature, optimism, or loss of control)

Appendix E

Brief RCOPE

The following items deal with ways you coped with the negative event in your life. There are many ways to try to deal with problems. These items ask what you did to cope with this negative event. Obviously different people deal with things in different ways, but we are interested in how you tried to deal with it. Each item says something about a particular way of coping. We want to know to what extent you did what the item says. *How much or how frequently*. Don't answer on the basis of what worked or not – just whether or not you did it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can. Circle the answer that best applies to you.

- 1 – not at all
- 2 – somewhat
- 3 – quite a bit
- 4 – a great deal

1. Looked for a stronger connection with God.	1	2	3	4
2. Sought God's love and care.	1	2	3	4
3. Sought help from God in letting go of my anger.	1	2	3	4
4. Tried to put my plans into action together with God.	1	2	3	4
5. Tried to see how God might be trying to strengthen me in this situation.	1	2	3	4
6. Asked forgiveness for my sins.	1	2	3	4
7. Focused on religion to stop worrying about my problems.	1	2	3	4
8. Wondered whether God had abandoned me.	1	2	3	4
9. Felt punished by God for my lack of devotion.	1	2	3	4
10. Wondered what I did for God to punish me.	1	2	3	4
11. Questioned God's love for me.	1	2	3	4
12. Wondered whether my church had abandoned me.	1	2	3	4
13. Decided the devil made this happen.	1	2	3	4
14. Questioned the power of God.	1	2	3	4

Appendix F**Adverse Childhood Experiences (ACE)****Finding Your ACE Score While you were growing up, during your first 18 years of life:**

1. Did a parent or other adult in the household **often or very 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

2. Did a parent or other adult in the household **often or very often...** Push, grab, slap, or throw something at you?

or

Ever hit you so hard that you had marks or were injured?

Yes/No

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

Attempt or actually have oral, anal, or vaginal intercourse with you?

Yes/No

4. Did you **often or very 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

Yes/No

5. Did you **often or very 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

6. Were your parents **ever** separated or divorced?

Yes/No

7. Was your mother or stepmother:

Often or very often pushed, grabbed, slapped, or had something thrown at her?

or

Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

Yes/No

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

Yes/No

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

Yes/No

10. Did a household member go to prison?

Yes/No

Appendix G

Brief COPE

These items deal with ways you've been coping with the stress in your life since you found out you were going to have to have this operation. There are many ways to try to deal with problems. These items ask what you've been doing to cope with this one. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

1 = I haven't been doing this at all

2 = I've been doing this a little bit

3 = I've been doing this a medium amount

4 = I've been doing this a lot

1. I've been turning to work or other activities to take my mind off things.
2. I've been concentrating my efforts on doing something about the situation I'm in.
3. I've been saying to myself "this isn't real."
4. I've been using alcohol or other drugs to make myself feel better.
5. I've been getting emotional support from others.
6. I've been giving up trying to deal with it.
7. I've been taking action to try to make the situation better.
8. I've been refusing to believe that it has happened.
9. I've been saying things to let my unpleasant feelings escape.
10. I've been getting help and advice from other people.
11. I've been using alcohol or other drugs to help me get through it.
12. I've been trying to see it in a different light, to make it seem more positive.
13. I've been criticizing myself.
14. I've been trying to come up with a strategy about what to do.
15. I've been getting comfort and understanding from someone.
16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.

18. I've been making jokes about it.
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
20. I've been accepting the reality of the fact that it has happened.
21. I've been expressing my negative feelings.
22. I've been trying to find comfort in my religion or spiritual beliefs.
23. I've been trying to get advice or help from other people about what to do.
24. I've been learning to live with it.
25. I've been thinking hard about what steps to take.
26. I've been blaming myself for things that happened.
27. I've been praying or meditating.
28. I've been making fun of the situation.

Appendix H

Trauma History Screen

The events below may or may not have happened to you. Circle “YES” if that kind of thing has happened to you or circle “NO” if that kind of thing has not happened to you. **If you circle “YES” for any events:** put a number in the blank next to it to show how many times something like that happened.

1. A really bad car, boat, train, or airplane accident
2. A really bad accident at work or home
3. A hurricane, flood, earthquake, tornado, or fire
4. Hit or kicked hard enough to injure - as a child
5. Hit or kicked hard enough to injure - as an adult
6. Forced or made to have sexual contact - as a child
7. Forced or made to have sexual contact - as an adult
8. Attack with a gun, knife, or weapon
9. During military service - seeing something horrible or being badly scared
10. Sudden death of close family or friend
11. Seeing someone die suddenly or get badly hurt or killed
12. Some other sudden event that made you feel very scared, helpless, or horrified.
13. Sudden move or loss of home and possessions.
14. Suddenly abandoned by spouse, partner, parent, or family.

NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES

NO YES NO YES NO YES NO YES

NO YES NO YES

Number of times something like this happened

_____ **Did any of these things really bother you emotionally? NO YES**

If you answered “YES”, fill out a box to tell about EVERY event that really bothered you.

Letter from above for the type of event: _____

Your age when this happened: _____

Describe what happened:

When this happened, did anyone get hurt or killed? NO YES

When this happened, were you afraid that you or someone else might get hurt or killed? NO YES

When this happened, did you feel very afraid, helpless, or horrified? NO YES

After this happened, how long were you bothered by it? not at all / 1 week / 2-3 weeks / a month or more

How much did it bother you emotionally? not at all / a little / somewhat / much / very much

Appendix I

Curriculum Vitae

Autumn Van Meter

800 West University Parkway
Orem, UT 84058
avanmeter@georgefox.edu
541-550-8872

Education

2011-present	Doctorate of Clinical Psychology George Fox University, Newberg, Oregon APA Approved Psy.D. Program Projected completion, April 2016
2011-2013	Masters of Clinical Psychology George Fox University, Newberg, Oregon
2007-2011	Bachelor of Science, Psychology George Fox University, Newberg, Oregon

Supervised Clinical Experience

8/2015 – Present	Utah Valley University, Student Health Services, Orem, UT APPIC Doctoral Intern <ul style="list-style-type: none">• Full time doctoral internship• Provide therapy for students attending the university• Administer integrated Learning Disability assessments, and ADHD evaluations• Participate in weekly individual and group supervision• Participate in weekly didactic training and grand rounds• Participate in weekly staff meetings• Supervise practicum students• Participate in outreach/programming for students• Co-teach group psychotherapy course, and teach undergraduate courses• Reviewed recorded therapy sessions in individual and group supervision settings Supervisors: Taige Bybee, Ph.D., Laura Heaphy, Psy.D., Kersten “Tess” Haugse White, Ph.D.
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- 8/2014-7/2015 **Willamette Family Medical Center, Salem, OR**
Therapist/Behavioral Consultant
- Preinternship practicum experience
 - Provide therapy for low income, underinsured patients from diverse backgrounds
 - Provide integrated health care, including reception of “warm-hand-offs” from primary care providers
 - Administer integrated cognitive and personality assessments for clinic patients
 - Participate in weekly individual and group supervision
 - Participate in weekly didactic training
- Supervisor: Joel Gregor, Psy.D.
- 7/2013-6/2014 **George Fox University Behavioral Health Clinic, Newberg, OR**
Assessment Coordinator
- Practicum II experience
 - Administration duties (contacting, scheduling, billing for assessments)
 - Selected and administered full batteries of assessments relative to referral question
 - Wrote comprehensive psychological reports including test results, interpretation, diagnosis and recommendations
 - Provided therapy for clients
 - Participated in weekly individual and group supervision
 - Participated in weekly didactic training
- Supervisor: Joel Gregor, Psy.D.
- 9/2012-5/2013 **North Clackamas School District, Rowe Middle School, Milwaukie, OR**
School Therapist
- Practicum I experience
 - Provided therapy, assessments, and behavioral interventions for middle school students
 - Weekly consultation with administration and staff
 - Assisted with academic planning, including IEP meetings and SpEd planning
 - Participation in weekly individual and group supervision
- Supervisor: Leslie Franklin, Ph.D.
- 1/2012-4/2012 **George Fox University Graduate Department of Clinical Psychology, Newberg, OR**
Therapist
- Pre-Practicum experience
 - Provided therapy for 3 college students for 10 sessions
 - Conducted intake interviews, developed treatment plans, wrote formal reports and completed termination summaries
 - Received weekly individual and group supervision
 - Reviewed recorded therapy sessions in individual and group supervision settings

- Participation in weekly clinical oversight team meetings
- Supervisors: Mary Peterson, Ph.D., Kim Kunze, M.A.

Research and Presentation Experience

- 2012-2016 **Dissertation Project**
Coping methods that predict reduced symptoms of Posttraumatic Stress Disorder (PTSD) for people who have experienced a traumatic event
 Original research project, including collection of data, statistical analysis and interpretation
 Final defense, full pass, February 2016
 Chair: Rodger K. Bufford, Ph.D. Committee: Kathleen Gathercoal, Ph.D., Kristie Knows His Gun, Psy.D.
- 2015 **Parenting Skills**
 Present to medical providers on how to teach basic parenting skills to parents of children with behavioral problems
 Salem, OR
 Supervisor: Joel Gregor, Psy.D.
- ADHD Psychological Assessment Presentation**
 Discussed referral questions, choosing assessment batteries, interpretation of results, recommendations, and therapeutic treatment implications related to psychological assessment of ADHD in children and adolescents
 Newberg, OR
 Supervisor: Elizabeth Hamilton, Ph.D.
- 2014 **Depression Presentation**
 Present psychoeducational information to undergraduates about etiology, symptoms, effects, and resources about depression
 Newberg, OR
 Supervisor: Kristie Knows-His-Gun, Psy.D.
- 2013-2014 **Research Assistant**
 Administration and scoring of the WRAML-2, a standardized cognitive measure, to adult volunteers as part of data collection for a dissertation assessing the memory implications from mild to moderate hearing loss.
 Newberg, OR
 Supervisor: Heather Deming, M.A.
- Ethics Committee Consultation Research Project and Presentation**
Review of Local Psychologists' Ethical Concerns as Reported to the Oregon Psychological Association's Ethics Committee
 Schloemer, J., Sieg, C., **Van Meter, A.**, Galindo, D., & Flores, M.
 Categorizing and analyzing data gathered by Oregon Psychological Association's ethics committee, including a presentation of findings to committee upon completion as well as written paper

In conjunction with OPA Ethics Committee Research
Poster presentation accepted to Oregon Psychological Association, Portland, OR
(May, 2014)

2013

Practicum Presentation

Woodcock Johnson, Third Edition, Tests of Achievement

Presented how to administer, score and interpret WJ-III-TA to fellow practicum colleagues

George Fox University Behavioral Health Clinic
Newberg, OR

Health and Wellness Expo Poster Presentation

Anti-Bullying

Presented information on prevention and interventions on bullying to Elementary and Middle school children.

Portland, OR

2011-2012

APA Research Poster Presentation

Luna, L., Miller, K., & Van Meter, A. (2012, August). *Measuring shame in Mexican-American adolescents: A comprehensive analysis.*

Poster session presentation at American Psychological Association Conference (2012)
Orlando, Florida.

2010-2011

Research Project

Paternal and Maternal Effects on Children's Motivation

Coding paternal intrusiveness on their children

George Fox University, Newberg, OR
Supervisor: Sue O'Donnell, Ph.D.

2010

Research Methods Project

The Effects of Suggestibility of Personality Types On College Age Participants

Designed, conducted, and presented research project in addition to writing a research paper.

George Fox University, Newberg, OR
Supervisor: Sue O'Donnell, Ph.D.

2009

Western Psychological Association Poster Project

Affect Regulation Styles, Life Satisfaction and Emotional Intelligence

George Fox University, Newberg, OR
Supervisor: Kelly Chang, Ph.D.

Relevant Work Experience

- | | |
|-------------------|---|
| 1/2015 – 5/2015 | George Fox University Graduate Department of Clinical Psychology,
Newberg, OR
<i>Graduate Teacher's Assistant</i> <ul style="list-style-type: none">• Graduate Neuropsychological Assessment• Teach and evaluate students learning how to administer neuropsychological assessments |
| 10/2014 – 12/2014 | George Fox University Graduate Department of Clinical Psychology,
Newberg, OR
<i>Graduate Teacher's Assistant</i> <ul style="list-style-type: none">• Graduate Cognitive Assessment• Review assessment reports and provide feedback on content, accuracy, and professional writing |
| 9/2014 – 12/2014 | George Fox University Psychology Department, Newberg, OR
<i>Teacher's Assistant</i> <ul style="list-style-type: none">• Undergraduate Advanced Counseling• Provide group supervision• Review videos and provide feedback on therapeutic skills |
| 9/2014 – 12/2014 | George Fox University Graduate Department of Clinical Psychology,
Newberg, OR
<i>Graduate Teacher's Assistant</i> <ul style="list-style-type: none">• Graduate Statistical Procedures• Participate in class activities, office hours to help with homework questions |
| 8/2013-6/2014 | George Fox University Graduate Department of Clinical Psychology,
Newberg, OR
<i>Graduate Teacher's Assistant</i> <ul style="list-style-type: none">• Practicum I Consultant• Consulting with first time practicum students about working in a school district |
| 9/2010-4/2011 | George Fox University Psychology Department, Newberg, OR
<i>Office/Teachers' Assistant</i> <ul style="list-style-type: none">• Office work: filing, printing, organizing etc.• Grading, correcting assignments, checking APA formatting |
-

Teaching Experience

- | | |
|----------------|--|
| 1/2016-Present | Adjunct Faculty
Psychology 1010: Introduction to Psychology
Utah Valley University
Supervisor: Kiera Davis, Ph.D., Course Director |
|----------------|--|

8/2013 – 12/2014	Adjunct Faculty Psychology 150: Introduction to Psychology George Fox University Supervisors: Jim Foster, Ph.D., Dean of College of Behavioral Health Services; Sue O'Donnell, Ph.D., Associate Professor
6/2014	Substitute/Guest Lecture , Newberg, OR George Fox University Graduate Department of Clinical Psychology <ul style="list-style-type: none"> • Provide lecture for Graduate level social psychology course
8/2011 – 5/2015	Substitute/Guest Lecture , Newberg, OR George Fox University Psychology Department <ul style="list-style-type: none"> • Provide lectures for Undergraduate Psychology Courses • Prepare, plan, and teach

Relevant Leadership Roles

2011-2013	Student Council , 1 st and 2 nd year representative, George Fox University, Newberg, OR
2009- 2010	Multicultural Club , co-coordinator, George Fox University, Newberg, OR

Additional Professional Training

8/2015-Present	<u>Weekly Didactic Training</u> Various topics related to college counseling services such as ethics, multicultural therapy and assessment
4/2016	<u>Mental Health Symposium</u> “Conference on Autism” Keynote presenters: Kristine Barnett, Stephen Shore, Ed.D., Sally Zonoff, Ph.D.
3/2016	<u>Mental Health Symposium</u> “Conference on Addiction” Keynote presenters: Sean Astin & Carl Hart, Ph.D.
1/2016	<u>Mental Health Symposium</u> “Focus on Trauma” Keynote Presenters: Sean Rayes, Utah Attorney General, Timothy Ballard, MA

- 10/2015 Utah University and College Counseling Centers Conference
 “Got competence? A new framework for counseling centers committed to multiculturalism”
 All day conference designed to support and create collaboration for university and college counseling centers located in Utah.
 Keynote Presenter: Karen Tao, Ph.D.
- 9/2015 Seminar
 Treatment Resistant Anxiety, Worry, and Panic: 86 Practical Treatment Strategies for Clinicians
 Presenter: Jennifer Abel, Ph.D.
- 6/2014-6/2015 Weekly Didactic Training
 Various topics related to integrated health care such as psychotropic medications, new wave CBT techniques, and commonly diagnosed disorders
 Presenter: Joel Gregor, Psy.D.
- 3/2015 Clinical Colloquia
 “Spiritual Formation and Psychotherapy”
 Presenter: Barrett McRay, Psy.D.
- 2/2015 Clinical Colloquia
 “Credentialing, Banking, the Internship Crisis, and other Challenges for Graduate Students in Psychology”
 Presenter: Morgan Sammons, Ph.D., ABPP
- 11/2014 Clinical Colloquia
 “Face Time in an Age of Technological Attachment”
 Presenter: Dorren Dodgen-Mcgee, Psy.D.
- 10/2014 Clinical Colloquia
 “ADHD: Evidence-based Practice for children and adolescents”
 Presenters: Erika Doty, Psy.D., Tabitha Becker, Psy.D.
- 8/2014 Integrated Care Training
 “Behaviorist Bootcamp”
 40 hour training preparing practicum students working in integrated care settings. Topics included, commonly diagnosed psychological disorders, medical disorders, and interventions designed for the setting
- 8/2013-6/2014 Weekly Didactic Training
 Various topics, including leading parenting groups, short-term solution focused psychotherapy, grief counseling, marital counseling and more
 Presenter: Joel Gregor, Psy.D.
- 3/2014 Medical University of South Carolina
 Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)
 An online interactive training course for TF-CBT with children and adolescents

Received 10 continuing education contact hours and a certification of completion of the course

Clinical Colloquia

“Evidence-based Treatments for PTSD in Veteran Populations: Clinical and Integrative Perspectives”

Presenter: David Beil-Adaskin, Psy.D.

1/2014

Clinical Colloquia

“DSM-5, Essential Changes in Form and Function”

Presenters: Jeri Turgesen, Psy.D., Mary Peterson, Ph.D.

11/2013

Clinical Colloquia

“African American History, Culture and Addictions and Mental Health Treatment”

Presenters: Danette C. Haynes, LCSW, Marcus Sharpe, Psy.D.

9/2013

Clinical Colloquia

“Integrated Primary Care”

Presenters: Juliette Cutts, Psy.D., Brian Sandoval, Psy.D.

6/2013

Clinical Colloquia

“The person of the Therapist: How Spiritual Practice Weaves the Therapeutic Encounter”

Presenter: Brooke Kuhnhausen, Ph.D.

5/2013

Northwest Psychological Assessment Conference

“Using tests of effort in a psychological Assessment”

Presenter: Paul Green, Ph.D.

“Assessing mild cognitive impairment and Dementia”

Presenter: Mark Bondi, Ph.D., ABPP

1/2013

Clinical Colloquia

“Afrocentric Approaches to Clinical Practice”

Presenters: Danette C. Haynes, LCSW and Marcus Sharpe, Psy.D.

10/2012

Clinical Colloquia

“Treating Gender Variant Clients: Christian Integration”

Presenter: Erica Tan, Psy.D.

8/2012

2012 APA Annual Convention

Attended various topics including, teaching at a community college, writing internship essays, religious diversity, introduction to the DSM-5, and more

6/2012

Northwest Psychological Assessment Conference

“Assessment and Treatment of Anger, Aggression, & Bullying in Children and Adults”

Presenter: Ray DiGiuseppe, Ph.D.

“The Mini-Mental State Examination – 2nd Edition”

Presenter: Joel Gregor, Psy.D.

3/2012

Clinical Colloquia

“Strengthening your Internship Applications”

Presenters: Elizabeth Goy, Ph.D. and David Indest, Psy.D.

3/2012

Clinical Colloquia

“Mindfulness and Christian Integration”

Presenter: Erica Tan, Ph.D.

11/2011

Clinical Colloquia

“Cross-Cultural Psychological Assessment”

Presenter: Tedd Judd, Ph.D.

10/2011

Clinical Colloquia

“Motivational Interviewing” & “A Work in Progress” What it is, & Why to use it

Presenter: Michael Fulop, Psy.D.

9/2010

APA Writing Style Workshop

George Fox University, Newberg, OR

Presenter: Sue O'Donnell, Ph.D.

References

Taige Bybee, Ph.D.

Licensed Psychologist
Director of Training
Utah Valley University
Clinical Supervisor
bybeeta@uvu.edu
801-863-7270

Rodger K. Bufford, Ph.D.

Licensed Psychologist
Professor of Psychology
Graduate Department on Clinical Psychology
George Fox University
Research Supervisor
rbufford@georgefox.edu
503-554-2374

Laura Heaphy, Psy.D.

Licensed Psychologist
Mental Health Therapist
Utah Valley University
Clinical Supervisor
laura.heaphy@uvu.edu
801-863-6388

Kristina Kays, Psy.D.

Licensed Psychologist
Assistant Professor of Psychology
George Fox University
Clinical supervisor
kkays@georgefox.edu
503-554-2762