IJSRM
INTERNATIONAL JOURNAL OF SCIENCE AND RESEARCH METHODOLOGY
An Official Publication of Human Journals

Human Journals
**Review Article**
May 2021 Vol.:18, Issue:3


# The Effects of Past Trauma on Current Mental Health

IJSRM
INTERNATIONAL JOURNAL OF SCIENCE AND RESEARCH METHODOLOGY
An Official Publication of Human Journals

**Kalyn R. Bodziak[1], Kylie J. Lothschutz[1], Caitlin M. Pung[1], Samuel P. Abraham[2*]**

*[1]Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA*

*[2*]Associate Professor of Nursing, Bethel University School of Nursing, Mishawaka, Indiana, USA*

**Submitted:** 21 April 2021
**Accepted:** 27 April 2021
**Published:** 30 May 2021



**Keywords:** traumatic experiences, mental health, past trauma, mental health disorders, adverse childhood experiences

## ABSTRACT

**Background:** Significant relationship exists between past trauma and current mental health problems many people face. Trauma is defined as deeply distressing or disturbing experiences. A traumatic experience can be described as an event or series of events that cause a significant amount of stress to the body and are marked by a sense of horror, helplessness, serious injury, or the threat of severe injury or death. Many people do not realize such experiences can affect them later on in life, whether that is physical or emotional. Mental health is just as important as physical health, and it is essential to provide awareness and resources to understand such effects trauma can have on mental health. **Purpose:** This review aims to determine the relationship past trauma has on current mental health. **Method:** A thorough review of the literature was initiated to identify studies on the concepts of trauma on current mental health. Three short case studies were also conducted to strengthen the findings. **Findings:** Past traumatic experiences have been shown to affect current mental health outcomes. Without appropriate intervention, these distressing events create lasting psychological consequences, including substance use disorder, major depressive disorder, post-traumatic stress disorder, and conduct disorder.

## INTRODUCTION:

Many mental health disorders can result from past trauma. An individual's response to trauma can vary from person to person. As illustrated in Figure 1, how a person responds to past trauma determines the outcome. Reactions to a traumatic experience can include feelings of fear, grief, and depression [1]. Physical and behavioral responses include nausea, dizziness, and changes in appetite and sleep pattern, and withdrawal from daily activities. Negative experiences in childhood and the teenage years may lead to a risk for chronic health problems, mental illness, and substance use in adulthood [1]. Past trauma and adverse childhood experiences (ACEs) can lead to various mental health problems, including anxiety, post-traumatic stress disorder (PTSD), depression, aggressiveness, suicidality, and ineffective coping mechanisms. The purpose of this review was to explore the relationship between past trauma and current mental health disorders. Through literature review and observations, the focus was to determine the answer to the question: How does past trauma affect mental health?

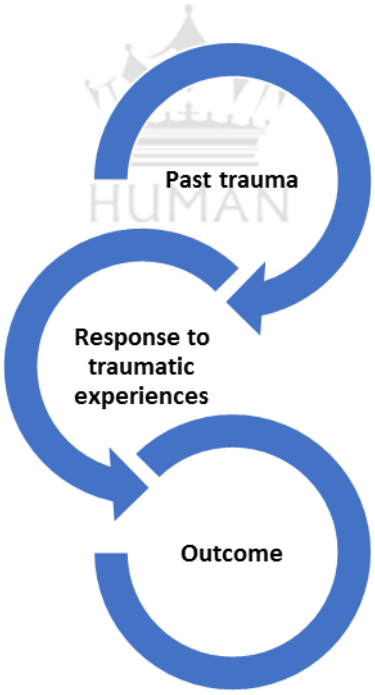



**Figure No. 1: How a person responds to past trauma determines the outcome**

## CASE STUDY

The clients included in these case studies had a mental illness. Each of their diagnoses and reasons for admission correlates with a history of traumatic experiences. Their personal stories reveal the harsh effects trauma can have on one's mental state and ability to function as a person in society. For confidentiality reasons, verbal consent was obtained for the case studies.

### Patient A

Admitted to a residential substance abuse unit, patient A was diagnosed with depression, anxiety, and alcohol use disorder. He reported drinking one pint of alcohol per day to cope with depressive and anxious symptoms. He described feelings of anergia, fatigue, and impairment in normal areas of function related to recent homelessness and abandonment of his current partner. Patient A described his lifelong struggle with anxiety and depression, contributing to his newlywed wife's diagnosis and passing from Multiple Sclerosis, and his son's tragic death in a car accident at a very young age. In turn, these traumatic experiences led to the client's current mental health disorders of anxiety and depression and created unhealthy coping mechanisms, resulting in alcohol use disorder.

### Patient B

Patient B was involuntarily admitted to an inpatient psychiatric unit after struggling with substance abuse and his diagnosis of bipolar disorder and depression. He reported drinking alcohol daily and using cocaine and cannabis daily before his admission. He described being raised in a household surrounded by drug and alcohol abuse. He stated as early as 14 years old, he began doing drugs. The patient did seem to have a flat affect when discussing these memories. He said that he had struggled with addiction since he started using substances. He believes that he would not have struggled as much in his life if he were raised differently. Due to the patient's traumatic experiences and substance use, he struggles with addiction and depression.

### Patient C

Patient C was a 30-year-old mother of five children who voluntarily admitted herself to an inpatient psychiatric unit after a suicide attempt where she overdosed on Tylenol. This client's social history involved being placed in foster care at 9-years-old after her mother overdosed on

heroin. She was separated from her mother and sister. The client was malnourished with multiple bruises and abrasions from abuse and neglect. The foster parent sexually abused her, so she was moved into a girl's residential treatment home where she resided until she was 17 years old. Patient C has been homeless ever since. She had a physically abusive boyfriend and struggled with substance abuse of alcohol and methamphetamines. Patient C reported this was her fourth suicide attempt in the last seven years. She was diagnosed with PTSD, attention deficit hyperactivity disorder (ADHD), and depression. These past traumas resulted in maladaptive coping patterns and a lack of support.

## LITERATURE REVIEW

In the process of conducting a literature review, databases such as the Centers of Disease Control and Prevention (CDC), Wiley Online Library, Taylor & Francis, Elsevier, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, and ProQuest were searched for articles ranging from 2016 to 2021. The concepts of trauma and mental health were discussed throughout each piece of literature. Topics such as childhood trauma and exposure to trauma and the relationship each holds with neurobiological development, substance abuse, mental health disorders, and violence were also discussed. This literature review contains information analyzing these concepts and defines specific mental health disorders and treatments for trauma.

### Childhood Trauma and Neurobiological Development

Cross *et al.* [2] conducted a literature review exploring how interpersonal childhood trauma affects the brain. Interpersonal trauma involves emotional abuse, emotional neglect, physical abuse, physical neglect, sexual abuse, and witnessing violence leading to chronic stress [3]. Childhood is a period of rapid brain development. When children grow up in a chaotic environment where their needs are not met, their brains develop differently than average children. Cross *et al.* [2] explained that chronic stress could promote adverse epigenetic and neurobiological mechanisms. Therefore, these clients are at risk for negative cognitive, emotional, and psychiatric outcomes [2].

Chronic fear contributes to chronic sympathetic nervous system stimulation, which includes the hypothalamic-pituitary-adrenal (HPA axis). This process can lead to prolonged elevation of serum cortisol levels, which can reduce neurogenesis, connectivity, and neuroplasticity in the

hippocampus, amygdala, and prefrontal cortex [2]. The prefrontal cortex is responsible for executive functioning: decision making, personality, behavior inhibition, goal-directed behavior, and distinguishing between good and bad [4]. The amygdala is connected to the hippocampus, and these regions regulate emotion and memory formation, respectively [4]. Disturbed executive function and emotional regulation are possible consequences of imbalanced brain maturation, placing children at risk for PTSD, dissociation, and depression [2].

Cross *et al.* [2] acknowledged that the timing of trauma impacts what neurobiological processes are affected. Furthermore, not every individual exposed to childhood trauma has HPA axis changes. Factors such as resilience and learned self-soothing mechanisms have a role in unique responses to trauma. Lastly, epigenetics is another area of research to be explored that may identify several specific genes expressed during or after traumatic experiences [2].

**Trauma, Disparities, and Academics**

In multiple studies regarding the effects of childhood trauma on mental health and academic achievement, Larson *et al*. [5] showed a significant risk of mental health disorders and poor academic achievement when exposed to childhood trauma. Children and adolescents of minority racial and ethnic groups and those living in poverty are at greater risk of exposure to trauma and are less likely to access mental health services [5]. They reviewed studies ranging from longitudinal interviews, cross-sectional surveys, and literature reviews to find their results showing the relationship childhood trauma has on psychiatric disorders. The developments of anxiety, depression, suicidality, conduct disorder, PTSD, and ADHD were present among childhood trauma victims (see Figure 2). Poor academic achievement was also prominent amongst these developments. Overall, chronic trauma in children negatively affects academics and mental health, and it is shown that disparities amongst children who experienced trauma are common in pediatric mental health [5].

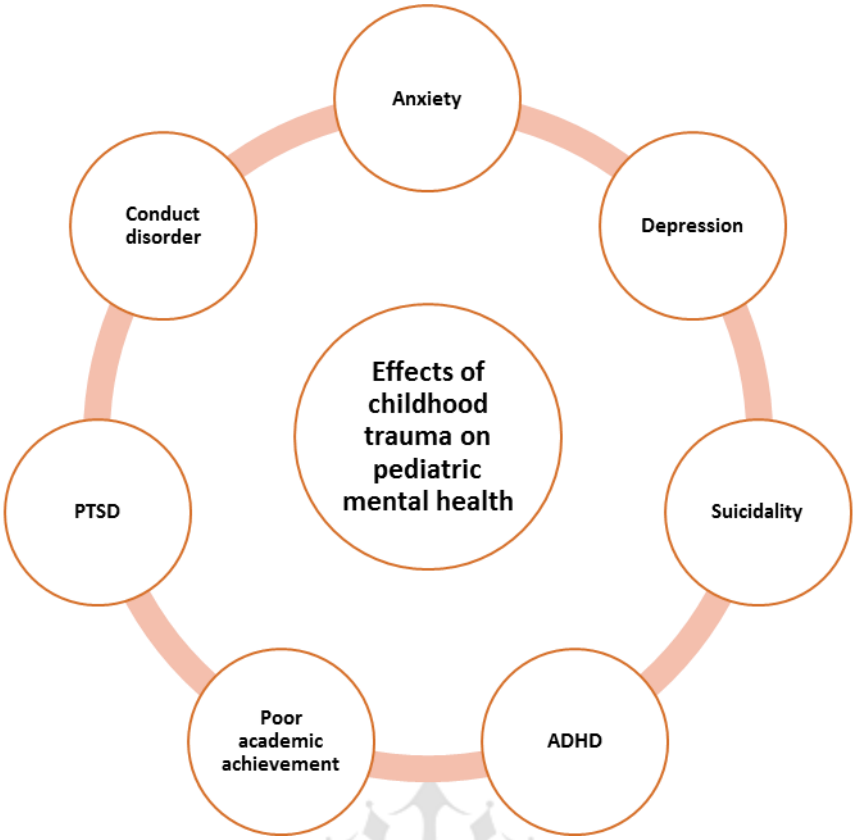



**Figure No. 2: Effects of childhood trauma on pediatric mental health**

**Post-Traumatic Stress Disorder**

Lee *et al.* [6] explained that mental health literacy is required to identify and manage mental health disorders. People able to identify mental health disorders correctly are more likely to seek help from a professional. PTSD was first introduced in 1980 mainly in response to Vietnam War veteran trauma. The authors focused on participants who had experienced PTSD symptoms to discuss their types of exposure to trauma and the rate of recognition and treatment they attained. Due to PTSD's original strong association with the military, many signs and symptoms were often referred to as the after-effects of combat rather than a mental response to trauma earlier in its diagnosing stage. PTSD was also found to be under-recognized among clinicians earlier on, implying sub-optimal intervention recommendations. PTSD can arise from a range of traumas, such as sexual or physical abuse, natural disaster, man-made disaster, and road traffic accidents [6]. Now, PTSD is one of the most widely known mental health disorders. Although for a while,

it was not diagnosed or recognized in many cases, especially cases with military pasts or those with indirect trauma, it is now one of the most known and treated mental health disorders today.

From a public health perspective, Kleber [7] emphasized that trauma can impact the individual and those around them (see Figure 3). A traumatic event experienced by an individual, such as rape, a death, or disaster, will be discovered by close family members and friends, one's social environment, and eventually, the community. Individuals within the community may feel hopelessness, powerlessness, despair, and self-blame related to the traumatic event. For many, this often results in PTSD, a mental health diagnosis associated with experiencing or witnessing a traumatic event. Although there have been many successful treatments for individuals with PTSD, there has been a lack of attention for managing public health trauma. Kleber calls on public health associations to prevent mental health problems and treat symptoms of these disorders accordingly. Preventing adversity, creating awareness and recognition, and strengthening resilience are strategies he suggests addressing mental health disorders related to trauma. In addition, counseling, reconciliation programs, an introduction of policies related to common risk factors, and early intervention strategies within communities will provide more positive public mental health outcomes [7].

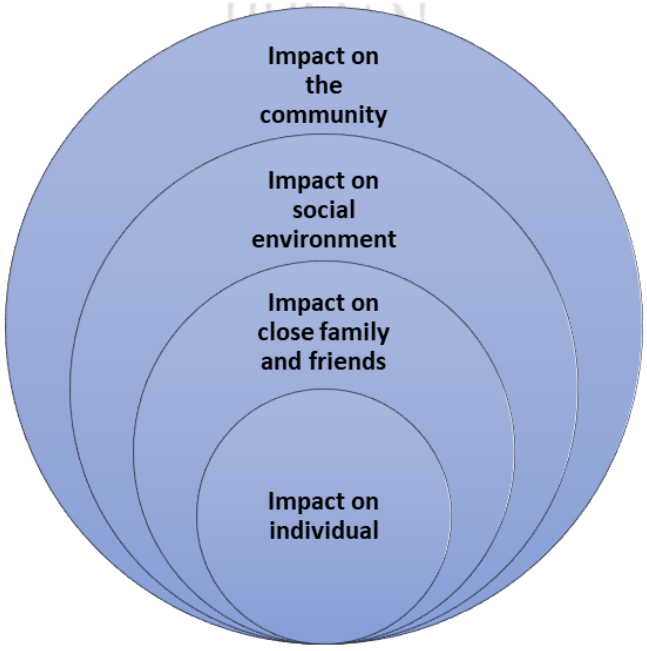



**Figure No. 3: Impact of trauma on the individual and those around them**

**Risk for Violence and Distress**

In a retrospective case study, authors Macinnes *et al.* [8] examined patients amongst several hospitals who experienced childhood trauma and how it predicted concepts such as the risk for violence and psychological distress. Previous research has found an association between childhood trauma and insecure attachment, psychological distress, risk of violence, and decreases in engagement in therapy. The authors reviewed large prospective studies that showed a strong relationship between childhood abuse and psychosis. The authors define Bowlby's 1980 definition of the theory of attachment as the universal human need to form close emotional bonds to achieve healthy development [8]. Relationships formed early on in life model future relationships and future interpersonal and psychological functioning. If a child is abused, they become insecurely attached, which places them at high risk of developing mental health disorders. Victims of different types of childhood abuse and neglect have also been found to be at a greater risk of conduct disorder and adult criminal behavior [8]. Overall, children who experienced abuse can form many different types of insecure attachments and have a greater risk for externalizing their distress and using violence.

**Substance Abuse**

Torgerson *et al.* [9] discussed how the sense of belonging could increase adult mental health and decrease risky alcohol abuse derived from childhood trauma. Alcohol use and abuse is a behavior that often stems from childhood trauma, as many people who have suffered from such traumatic childhood experiences resort to substance abuse to help them cope. A sense of belonging in close relationships is hypothesized to promote resiliency against the negative outcomes of childhood trauma experiences. Belonging can refer to inclusion in social groups, close personal relationships, or purpose in one's roles in a family or community and is positively associated with meaningfulness in life. A sample of more than 600 adults was used to examine the relationship between childhood traumatic experiences and adult risky alcohol use mediated by mental health status and perceptions of belonging [9). This study indicated that having a greater sense of belonging was associated with a greater mental health state and reduced reports of risky alcohol use.

Adams *et al.* [10] explored predictors of substance use with alcohol and cannabis among adolescents pursuing treatment for trauma-related mental health problems. Teens studied all reported a minimum of one experience involving interpersonal violence (sexual abuse, physical abuse, physical assault, etc.) and use of either cannabis or alcohol in the past 90 days. In addition, the youth presented five or more PTSD criteria [10]. Findings indicated adolescents most often used cannabis as a coping mechanism, as well as for the enhancement effects of the drug. Alcohol use, however, was most associated with avoidance and depressive symptoms, with the social aspect of alcohol use being a significant predictor of alcohol use among teens [10]. By understanding predictors of substance use, healthcare professionals can more appropriately formulate interventions to combat inappropriate substance use and abuse, especially in the vulnerable adolescent population.

**Intimate Partner Violence**

Intimate Partner Violence (IPV), or the physical, sexual, or psychological abuse or violence from an intimate partner, has also been shown to increase the incidence of mental health disorders in affected individuals [11]. In a study done on the prevalence of mental health disorders and IPV within the past year in both veteran and non-veteran women receiving care in the Veteran's Health Administration (VHA), over half of the IPV+ women surveyed had a mental health diagnosis, compared to only one-third of the IPV- group. In addition, for women with a positive IPV screen, results indicated that the likelihood of being diagnosed with a mental health condition such as anxiety, PTSD, depression, alcohol, or drug abuse is more than double for those screened IPV+ than those who screened IPV-. Most commonly experienced by women, IPV also poses a threat for unwanted pregnancies and exposure to sexually transmitted infections. These complications, along with the negative stigma associated with sexual violence, can introduce more complex mental health outcomes [11]. Figure 4 illustrates the problems that increase the incidence of mental health disorders.

**Adverse Childhood Experiences**

Trauma related to ACEs has also been shown to affect mental health outcomes. Troubling incidents can lead to mental health complications, such as major depressive disorder and substance use disorder, in individuals who have difficulty coping with the persistent reminder of

such events. Upon evaluating patterns between ACEs, substance use disorder, and major depressive disorder in older adults, Kim *et al.* [12] found that older adults who experienced "high adversity" as a child (i.e., physical abuse, emotional abuse, the witness of IPV, or living with an adult with a substance disorder) were more likely to have had a substance use disorder or major depressive disorder within the past year compared to lower adversity classes. In addition, having a substance use disorder and major depressive disorder were positively associated among participants. With more insufficient reporting of ACEs in the older adult population, healthcare professionals must perform proper screening and assessment and provide interventions for alcohol, drug use, and depressive symptoms accordingly [12].

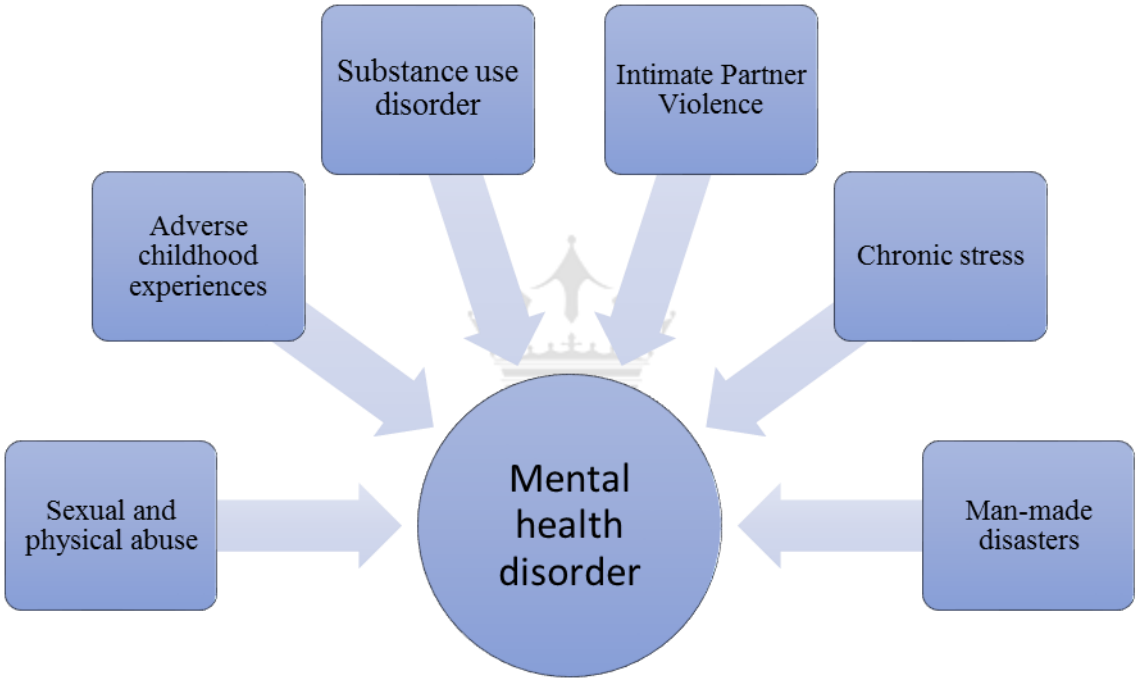



**Figure No. 4: Problems that increase the incidence of mental health disorders**

**Promoting Resilience**

Sciaraffa *et al.* [13] researched protective factors that minimize the long-term effects of ACEs. Resilience is the ability to bounce back from personal challenges and involves positive adaptations of the brain. The authors summarized that having secure attachments encourages healthy brain development and a sense of belonging. Secure attachments include parents, caregivers, and childhood educators, for example. In addition, helping children learn how to regulate their emotions and express their feelings constructively promotes social competency,

self-efficacy, and self-soothing mechanisms. For instance, talking with children about their feelings during playtime, recognizing and responding to a child's distress promptly, and modeling emotional regulation are methods to strengthen coping skills. Lastly, the funding of community resources is another component to buffer the impacts of ACEs. Community initiatives may include educating education staff about trauma and providing families with dependable, safe, and affordable childcare [13]. With support, it is possible to overcome trauma.

**Trauma-Focused Treatment**

Farnia *et al.* [14] conducted a quasi-experimental study researching the efficacy of trauma-focused cognitive-behavioral therapy (CBT) and theory of mind. Trauma-focused CBT concentrates its efforts on developing adaptive emotional regulation. Activities include managing emotional responses toward trauma, deep muscle relaxation, cognitive confrontation, and increasing environmental supports. Theory of mind teaching enhances a person's ability to recognize a person's mental state as different. Concepts revolve around recognizing emotional states, thinking-stopping, the relationship between thinking, emotions, and behavior, and how to increase environmental protections. In other words, restoring deficits in the theory of mind improves social interaction and responsiveness to emotional cues [14]. They evenly divided 39 participants into trauma-focused CBT, theory of mind, and control groups. Farnia *et al.* [14] utilized Kilmer's Posttraumatic Growth Inventory and Garnefski Emotional Regulation Questionnaire to measure baseline and post-intervention information about the participants. They calculated statistically significant improvements in post-traumatic growth and adaptative and maladaptive regulation within the trauma-focused CBT group ($P<0.001$), but the results for the theory of mind and the control group were not significant. Francia *et al.* [14] explained that Trauma-Focused CBT helps subjects manage their thoughts, while the theory of mind simply encourages subjects to identify their thoughts. Nonetheless, the theory of mind may be a beneficial treatment for improving social interaction.

**Trauma Resiliency Model**

In addition to cognitive therapies, there are somatic therapeutic approaches for trauma. Grabbe and Miller-Kraus [15] presented the current evidence for the practicality of the trauma resiliency model (TRM). The TRM consists of nine skills to support emotional regulation, self-awareness,

resilience, and processing traumatic memories. Being able to convert sensations of discomfort into feelings of wellness while confronting a traumatic memory is the goal of this treatment.

Anyone, such as a nurse, can teach the first six skills, but the last three skills require an advanced psychiatric professional. Grabbe and Miller- [15] summarized that these skills might promote positive neural pathways and responses to chronic stress. Tracking and resourcing are the first two skills. These skills require a person to identify negative feelings in response to trauma, followed by thinking of a positive idea that brings comfort. Grounding is the third skill that reinforces a person's presence in reality by feeling the floor or other surfaces. Gesturing is the fourth skill consisting of performing calming physical movements. The fifth skill is the "Help now!" step that encourages the client to reduce stress by performing simple, distracting activities such as counting steps or looking for colors. Shift and stay in the sixth step where the client can become consciously aware of stress and choose one of the first five skills to cope. Titration is a method used to reduce sensitivity to the traumatic event, and pendulation reminds the client to bring awareness to less tense areas of the body to decrease negative emotions. Lastly, completion allows the client to re-experience the body's natural response to stress in a safe environment to bring awareness to these reactions.

**SUMMARY:**

The literature review revealed several themes regarding past trauma and current mental health. The review results are consistent with the conclusion that past trauma promotes the development of mental illness. Findings thus far suggest these individuals are at significant risk for mental health disorders such as depression, anxiety, dissociation disorders, substance abuse, PTSD, suicidality, and conduct disorders.

**DISCUSSION:**

Several studies found resilience to be a critical component impacting the outcomes of traumatized individuals. For example, an important protective factor against mental health disorders is developing meaningful relationships, especially in infancy. Macinnes *et al.* [8] highlighted the universal human need to form relationships using Bowlby's 1980 definition of attachment theory. This theory is related to Erikson's theory of psychosocial development, for example, the trust versus mistrust stage [4]. When a baby cries and a caregiver responds, the

baby learns he or she is loved and cared for and develops a sense of self and security. However, if no one responds to the baby's cry, the baby experiences stress and a lack of security. Over time, chronic stress can lead to unhealthy brain development and coping mechanisms [2]. However, by developing meaningful relationships, people feel a sense of belonging and safety, which allows them to practice emotional regulation. If someone is in a chronic stress state, they are not nurturing the parts of their brain involved in self-soothing mechanisms and adaptation. Human connection is often underestimated in its healing abilities.

Nurses can help traumatized individuals. Farnia *et al.* [14] illustrated trauma-focused CBT to be an effective treatment. Educating and referring patients to these resources to obtain treatment are roles a nurse fulfills. In addition, Grabbe and Miller-Kraus [15] mentioned nurses can teach the first six somatic skills in the TRM to manage feelings associated with trauma. Lastly, it is important to mention Sciaraffa *et al.* [13] and Kleber [7] emphasized that trauma treatment requires community-wide interventions. Supporting or advocating for public health initiatives relevant to trauma is another method to improve treatment (see Figure 5).

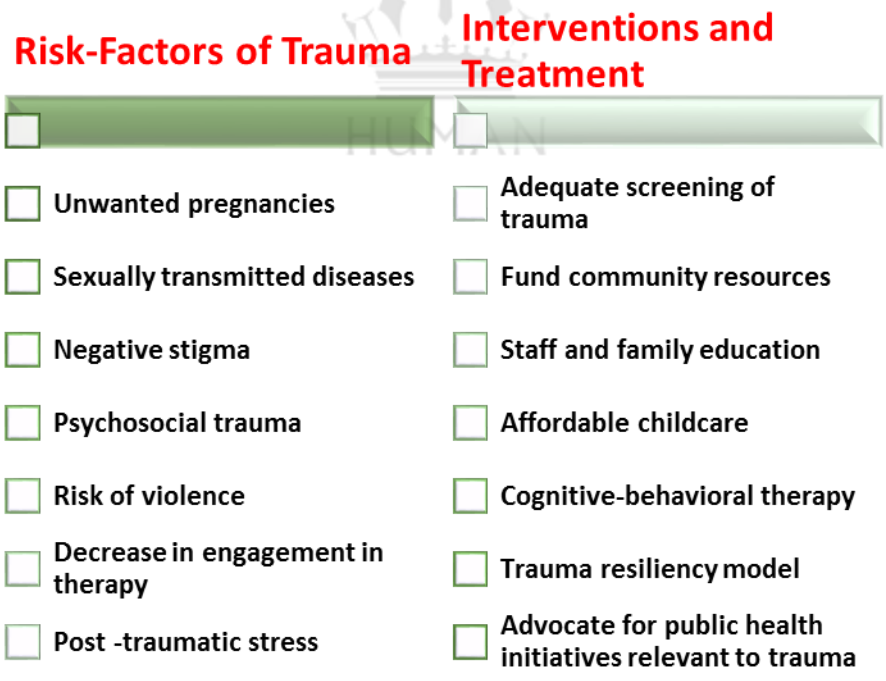



**Figure No. 5: Risk factors, interventions, and treatment for trauma causing mental distress**

Nurses should be aware that everyone does not respond to trauma equally. Nonetheless, nurses should strive to execute quality person-centered care. Helping patients identify realistic goals is

the first step in creating a nursing care plan. The client will verbalize at least two coping skills for anxiety by the end of the shift, or the client will identify at least two triggers for stress within one week are two patient-centered care goals. Nurses should respect people's body space, understand that certain things can trigger people, ask their patients if something is bothering them, and hold a stigma-free perspective. Treating people as human beings with dignity also encourages healing and the formation of connection.

**CONCLUSION:**

Through research, past traumatic experiences have been shown to affect current mental health outcomes. Without proper intervention, these distressing events create lasting psychological consequences, including substance use disorder, major depressive disorder, PTSD, conduct disorder, and many others. Nurses and other healthcare professionals must implement adequate trauma screening and its associated disorders for patients who have experienced these events. Additionally, it is necessary to offer support and provide resources for individuals suspected of dealing with current trauma.

As healthcare professionals, it is crucial to be mindful of the internal struggles faced by everyone who has endured trauma. Using therapeutic communication, remaining with a patient, and allowing the client to express their concerns and feelings will provide a comforting milieu and empower them to take the next steps towards combating the effects of their experiences. Using a patient-centered approach, the healthcare team and client can collaborate to find appropriate interventions for positive mental health outcomes. In doing this, it is important to remind clients that they are not defined by their past traumatic experiences and current mental health disorder but by their ability to seek resilience and overcome lifelong hardships.

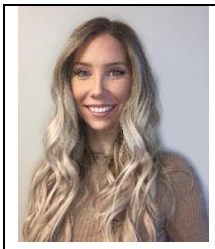
**REFERENCES:**

1. Centers for Disease Control and Prevention. (2020, April 3). *Adverse childhood experiences (ACEs)*. Retrieved from https://www.cdc.gov/violenceprevention/aces/

2. Cross, D., Fani, N., Powers, A., & Bradley, B. (2017). Neurobiological Development in the Context of Childhood Trauma. *Clinical Psychology: A Publication of the Division of Clinical Psychology of the American Psychological Association*, *24*(2), 111–124. https://doi.org/10.1111/cpsp.12198

3. Mauritz, M. W., Goossens, P. J., Draijer, N., & van Achterberg, T. (2013). Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *European Journal of Psychotraumatology*, *4*(1), 1-15. https://doi.org/10.3402/ejpt.v4i0.19985

4. Halter, M. (2018). *Varcarolis' foundations of psychiatric-mental health nursing, a clinical approach* (8th Ed.). St. Louis, MO: Elsevier.
5. Larson, S., Chapman, S., Spetz, J., and Brindis, C. (2017). Chronic childhood trauma, mental health, academic achievement, and school-based health center mental health services.*The Journal of School Health,* 87(9), 675-86. https://doi.org/10.1111/josh.12541
6. Lee, C., Furnham, A., &Merritt, C. (2016). Effect of directness of exposure and trauma type on mental health literacy of PTSD. *Journal of Mental Health*, 26(3), 257-63. https://doi.org/10.1080/09638237.2016.1276531
7. Kleber, R. J. (2019). Trauma and public mental health: A focused review. *Frontiers in Psychiatry*, *10*. https://doi.org/10.3389/fpsyt.2019.00451
8. Macinnes, M., Macpherson, G., Austin, J, & Schwannauer, M. (2016). Examining the effect of childhood trauma on psychological distress, risk of violence and engagement, in forensic mental health. *Psychiatry Research,246*, 314-320. https://doi.org/10.1016/j.psychres.2016.09.054
9. Torgerson, C., Love, H., & Vennum, A. (2018). The buffering effect of belonging on the negative association of childhood trauma with adult mental health and risky alcohol use. *Journal of Substance Abuse Treatment*, *88*, 44-50. https://doi.org/10.1016/j.jsat.2018.02.005
10. Adams, Z. W., Hahn, A. M., McCart, M. R., Chapman, J. E., Sheidow, A. J., Walker, J., … Danielson, C. K. (2021). Predictors of substance use in a clinical sample of youth seeking treatment for Trauma-related mental health problems. *Addictive Behaviors*, *114*, 1-6. https://doi.org/10.1016/j.addbeh.2020.106742
11. Dichter, M. E., Sorrentino, A., Bellamy, S., Medvedeva, E., Roberts, C. B., & Iverson, K. M. (2017). Disproportionate mental health burden associated with past-year intimate partner violence among women receiving care in the Veterans Health Administration. *Journal of Traumatic Stress*, *30*(6), 555–563. https://doi.org/10.1002/jts.22241
12. Kim, Y., Kim, K., Chartier, K. G., Wike, T. L., & McDonald, S. E. (2019). Adverse childhood experience patterns, major depressive disorder, and substance use disorder in older adults. *Aging & Mental Health*, *25*(3), 484–491. https://doi.org/10.1080/13607863.2019.1693974
13. Sciaraffa, M. A., Zeanah, P. D., & Zeanah, C. H. (2018). Understanding and promoting resilience in the context of adverse childhood experiences. *Early Childhood Education Journal*, *46*(3), 343-353.https://doi.org/10.1007/s10643-017-0869-3
14. Farnia, V., Naami, A., Zargar, Y., Davoodi, I., Salemi, S., Tatari, F., . . . Alikhani, M. (2018). Comparison of trauma-focused cognitive behavioral therapy and theory of mind: Improvement of post-traumatic growth and emotion regulation strategies. *Journal of Education and Health Promotion*, *7*(1), 58. http://doi.org/10.4103/jehp.jehp_140_17
15. Grabbe, L., & Miller-Karas, E. (2018). The trauma resiliency model: A "bottom-up" intervention for trauma psychotherapy. *Journal of the American Psychiatric Nurses Association*, *24*(1), 76-84. http://doi.org/10.1177/1078390317745133

| | |
|---|---|
|  | **Kalyn R. Bodziak**<br><br>*Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA* |
|  | **Kylie J. Lothschutz**<br><br>*Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA* |
|  | **Caitlin M. Pung**<br><br>*Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA* |
|  | **Dr. Samuel P. Abraham– *Corresponding Author***<br><br>*Associate Professor of Nursing, Bethel University, 1001 Bethel Circle, Mishawaka, Indiana, USA* |