Losing Faith: Effects of Trauma on Faith-Based Practices

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Spiritual and religious practices have provided a fundamental moral structure to humanity throughout our evolutionary journey. Émile Durkheim's *The Elementary Forms of Religious Life* (1912) draws attention to the collective effervescence associated with religious practices as it relates to the collective processes in which we engage. While there are nearly 10,000 distinct religious groups across the globe, there are only four religions that account for approximately 77% of our world's practices: Christianity (31%), Islam (24%), Hinduism (15%), and Buddhism (7%) (Wasserman, 2024). The organized religions that dominate spiritual ideology across the globe have an undeniable force that brings people together or isolates them from one another.

Durkheim asserts the "religious experience" to be shaped by societies collective forces which supports his claim that religious forces are human forces (Durkheim, 1912). Components of Durkheim's work pave the way for researchers to investigate how faith-based practices have impacted human experience. The design of this research study provides an examination of how traumatic life experiences impact an individual's faith-based practices.

As outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (2022), clinical professionals recognize that the components of trauma have the capacity to cause significant clinical distress amounting to the development of trauma- and stressor-related disorders. The scope of this research is limited to comprehensive analysis of patients, older than age six, diagnosed with posttraumatic stress disorder (PTSD) and how their faith-based practices were impacted by the trauma they endured. Diagnostic criteria for PTSD outline dissociative reactions, avoidance, detachment or estrangement from others, distorted cognitions, irritability, and self-destructive behavior as several of the criteria patients meet before being diagnosed (American Psychiatric Association, 2022). The duration of the disturbances and the impairment on the

patient's social or cognitive functioning is an essential component of diagnostic review (American Psychiatric Association, 2022). Trauma, as defined in PTSD diagnostic criteria A of the *Diagnostic and Statistical Manual of Mental Disorders*, serves as the definition chosen to guide this research.

While patients diagnosed with PTSD experience differences in symptomology, this research study aims to analyze the ways in which a patient's symptoms correspond to their faith-based practices. Avoidance, detachment or estrangement from others, and irritability are a fair few of the symptoms that could result in a patient's social disconnect. With Durkheim's theory regarding our religious experience, we can assume that without collective societal force or effervescence, our ties to faith-based practices can weaken significantly once induced by trauma. The hypothesis that PTSD is related to the impairment of a patient's ability to engage in faith-based practice guides the methodology of this study. The independent variable (PTSD) will be measured by the impacts of the dependent variable (faith-based practices).

Motivating forces for conducting research concerning PTSD and the challenges it creates for patients' level of engagement in their faith-based practices arose when I began engaging in reflection concerning my own experiences with this phenomenon. The traumatic loss of my mother brought on a multitude of immediate changes in my life. Disconnection from my faith ensued because of the development of my trauma-related disorder. Preceding the onset of my PTSD, my faith-based practices were considered personal and family-centered. Catholicism, predominantly Christianity, were the primary sources of my religious beliefs that guided my faith. My faith was a component of the inner peace I held within my heart and mind to center myself when I found myself straying away from homeostatic balance. The symptoms of PTSD tainted my faith-based practices, which further altered my capabilities to self-regulate. This

inability to self-regulate led to my disconnection from social connection and religious experience.

Restoring my faith was made possible by studying the fields of psychology, theology, anthropology, and sociology. The teachings from these academic fields guided my search for peace and self-actualization as I recovered from the loss of my mother and my faith. This study aims to uncover the stories of participants who have disconnected from their faith because of the trauma they experienced. Analysis of these stories will provide validity for the hypothesis based on qualitative and quantitative measurements.

Literature Review

Justyna Kucharska's research from *Religiosity and the concept of god moderate the relationship between the type of trauma, posttraumatic cognitions, and mental health* suggests that religiosity has the potential to provide individuals with protective factors against negative posttraumatic cognitions. Alternatively, religiosity can impact the level of severity in which symptoms are endured following sexual traumatic experiences. This study reflected how religiosity could have a protective or helpful effect while coping with trauma. While Kucharska's study assesses a specific group of traumatized participants, her data supports the relevance of existing correlations between post-traumatic stress cognitions.

While Justyna Kucharska researched *Religiosity and the psychological outcomes of trauma: A systematic review of quantitative studies*, she came across difficulty comparing the data. This occurred across studies due to variance within conceptualization of religiosity, types of traumas, and cultural context. The concepts measured proved that there is need for further studies to be conducted to better understand the phenomena of religiosity as it correlates with cognitive development.

The relevance that Kucharska's systematic review of quantitative studies has to my proposed hypothesis is reflected by the findings of moderate evidence that religiosity can be associated with better cognitive functioning or mental health. This review outlines significant findings relative to how an individual's level of religiosity can predict their levels of posttraumatic growth. While the severity of symptoms associated with posttraumatic stress disorder diagnosis is not fully understood in regard to one's level of religiosity, this leaves much room for this research question to aid academic pursuits and scientific inquiry.

Research on *Childhood Trauma and Experience in Close Relationships Are Associated with the God Image: Does Religiosity Make a Difference?* conducted by Kosarkova et al. sought out participants who reported childhood trauma. Participants were found to have decreased likelihood of reporting positive images of God (i.e. they described God as being an aversive or critical force as opposed to being positive or loving). It is assumed based on the findings of past and present research that childhood trauma survivors transmit their negative feelings of self-worth, guilt, and shame into their spiritual or religious dimensions. The research within this study represents congruent with the hypothesis that there are correlations between trauma symptoms and levels of religiosity. Additionally, the grounds to assume that faith-based practices or religiosity is impaired by trauma or posttraumatic stress disorder symptoms is supported by the findings within this research. Participants display decreased likelihood of religiosity and faith-based practice involvement due to having survived trauma. Their overall regards for God as a spiritual or religious guide have been significantly altered by their traumatic experiences.

Higher religiosity and spirituality are associated with ethnic group membership among middle-aged and older adults living with HIV. (Delgadillo et al., 2022) studied the experiences among people living with HIV- seeking to find if a greater engagement in spiritual or religious

based behaviors was associated with greater social support. Furthermore, people living with HIV indicated greater engagement in spiritual or religious based behaviors due to social support and identifying a stronger racial/ethnic membership. In relevance to my hypothesis, we can see within this study that when people who live with chronic medical conditions (such as HIV), there are great benefits to adopting forms of religiosity to cope with changes in their livelihood. Such changes, if not addressed, can weigh on the wellbeing of an individual's cognitive ability.

While people with HIV are living longer than ever before, this is still a potentially traumatic diagnosis to be given. The level to which people with HIV are or are not traumatized by their current state of health is seemingly dependent on their level or social support- to which this study shows how religiosity can provide such social support to those living with HIV. It is unclear how HIV positive individuals may internalize their diagnosis based on the information provided within this study. Thus, the identification of whether they can be considered relative to my inquiry question is uncertain. However, the nature of support to my hypothesis proves that the information within this study can be considered valuable, as it strongly supports hypotheses 2a and 2b.

Impact of Religiosity on Delirium Severity Among Critically Ill Shi'a Muslims: A Prospective Multi-Center Observational Study. (Farzanegan et al., 2021) implemented a thorough assessment of critically ill Shi'a Muslims and the severity of their symptoms relative to cognitive decline. Evidence within this study is suggestive of religion and spirituality having positive correlation between mental and physical health outcomes within the participant population. Both the research question and hypothesis can be supported by this study, as the religiosity within the studied group was strongly associated with feelings of relief, improvement in health behaviors, and overall acceptance for their current human condition

When studying measures of religiosity, posttraumatic stress disorder symptoms, and other clinical mental health disorders (anxiety and depression), religiosity was significantly related to the amount of hope that a U.S. Veteran emulated. The study *Hope, Religiosity, and Mental Health in U.S. Veterans and Active Duty Military with PTSD Symptoms*. (Koenig et al., 2020) was indicative that hope is perhaps inversely related to posttraumatic stress disorder and other measured clinical mental health disorder symptoms. Hope, related to both variables separately, is signified by this study to deny any indication between religiosity providing hope for U.S. Veterans with posttraumatic stress disorder and other clinical mental health disorders (anxiety and depression).

Relevance to hypothesis 2b of my research design could be found through this data-signifying that an individual's faith-based practices (religiosity) are moderated by independent coping skill factors (hope). While hope is not considered a part of religiosity nor a coping skill for managing mental health symptoms within the scope of this research, I would argue that hope conceptually has the potential to be manipulated as a variable attributed to either a coping skill for trauma survivors or an active practice of one’s religiosity.

The relevance to my research question can be uncovered through the participant characteristics found by conducting a questionnaire to uncover the relevance of the participants religious involvement, social factors, and posttraumatic stress disorder symptoms. These criteria for research allow for cross-reference and analysis of data collected through similar methods of research on the topic of trauma and religiosity.

The dimensions of symptom clusters for participants in study *Dimensions of Religiosity and PTSD Symptom Clusters in US Veterans and Active Duty Military.* (Koenig et al., 2019) were distinguished by the DSM-5 criteria for posttraumatic stress disorder. Inversely, religiosity

having been most related to negative cognitions or emotions (DSM-5 criterion D) and least associated with neurobiological symptoms (DSM-5 criterion B, C, and E) was the formative hypothesis for this research. Relevance to my hypothesis can be traced to the specific findings of the study- where religious struggles were relative to all four clusters of symptoms that received analysis. The relevance to my research question is conditional for this study- as some racial groups who participated were more or less likely to feel disconnected from their religiosity based on their posttraumatic stressors.

Posttraumatic Growth in U.S. Military Veterans: Results from the National Health and Resilience in Veterans Study. (Kang et al., 2024) was intended to outline the positive psychological changes or posttraumatic growth (PTG) in U.S. Military Veteran participants. This research design was created to uncover answers to what methods of recovery are most significant for positive psychological changes or posttraumatic growth (PTG). The intrinsic religiosity of participants was identified to be the strongest predictor of PTG. This is consistent with a 2011 study of veterans.

This study supports that positive associations with religiosity may have a greater likelihood to develop PTG. While PTG may also inspire people to want to grow spiritually, the evidence reflects significance that is needed to be studied further to comprehend the broad scope of posttraumatic stress disorder and religiosity. The concept and nature of this research is significant to the inquiry of my research, as outlined by my research question and hypotheses. While the overall hypothesis and question of this study was not created with the intent of discovering significance within the participants intrinsic religiosity, this is what was found. Therefore, this study remains relevant to my current method of research inquiry regarding trauma and religiosity.

Moral Injury, Religiosity, and Suicide Risk in U.S. Veterans and Active Duty Military with PTSD Symptoms. (Ames et al., 2019) outlines how a significant moral injury (MI), or threat to one's sense of self, is associated with greater risk of suicide within the population of U.S. veterans and active-duty military personnel. Those who meet the criteria for posttraumatic stress disorder have a higher risk for developing a MI. MI's definition indicates the spiritual component that poses relevant to the hypothesis and research question for my study design. The study finds that loss of religious faith/hope (as well as shame, feelings of betrayal, and self-condemnation) are MI characteristics strongly associated with suicide risk.

Prevalence of and factors associated with subclinical posttraumatic stress symptoms and PTSD in urban and rural areas of Montana: a cross-sectional study. (Erickson et al., 2013) seeks to understand posttraumatic stress disorder (PTSD) and posttraumatic stress symptoms (PTSS) in urban and rural areas of Montana. Risk and protective factors were considered by differences in rurality. The study found that risk and protective factors across urban and rural areas need to be understood further before running further analysis. Overall, the concept of this study is significant, and I admire the way they compared trauma symptoms from rural and urban populations within a singular state. However, this can be a tricky way to approach a study of two separate population groups. This study is mentioned due to the relevance of inquiring about each group (rural and urban) levels of religiosity. This is a beneficial factor to address, however, it did not work for the scope of this study. Since this study does not directly address a common experience of perceived trauma (i.e. a large-scale catastrophe or tragedy), therefore it was not conclusive. If this study was replicated in an applicable or suitable setting, it might have a better chance at providing more conclusive data. Once there is a distinct group of participants identified to be studied for my research, Erickson et al. study could serve as a reference.

Research Question

Are symptoms of posttraumatic stress disorder related to disconnection from an individual's faith-based practices? The question that outlines this study will serve as a guide to navigate the search for knowledge about the clinical significance between an individual's trauma and their spiritual disconnect. The operational definition of faith-based practice is predicated on the candidates' religious or spiritual alignments that will be understood through a series of questions presented though a formal intake interview process to determine whether the candidate meets the diagnostic criteria required for the study. In addition, candidates will be required to share information about their medical history regarding their posttraumatic stress disorder diagnosis, which they received from a medical or clinical professional. The candidates' diagnosis is required to have been made no less than one month from the time of their intake interview and must still meet diagnostic criteria for posttraumatic stress disorder at the time of the interview. Once this information is verified and reviewed, the candidate can receive their interview to assess whether they meet additional criteria necessary to participate.

The posttraumatic stress disorder symptoms of the participants will include specific negative alterations in cognitions and mood associated with the traumatic event as outlined in criteria D of the *Diagnostic and Statistical Manual of Mental Disorders*. Diagnostic criteria D.2., D.3., D.4., D.5., D.6. are the symptoms considered to have met the research needs for this study. Definitions for D.2.-6. from the *Diagnostic and Statistical Manual of Mental Disorders* (2022) are as follows:

> 2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").

3.Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

5. Markedly diminished interest or participation in significant activities.

6. Feelings of detachment or estrangement from others. (p. 303)

Null Hypothesis (H_0)

There is no significant relativity between symptoms of posttraumatic stress disorder and an individual's faith-based practices.

Alternative Hypothesis (H_1)

Symptoms of posttraumatic stress disorder have negative correlation with an individual's faith-based practices- as symptoms of posttraumatic stress disorder increase, the individual's faith-based practices decrease.

Hypothesis 2 (H_2)

The correlation between symptoms of posttraumatic stress disorder and an individual's faith-based practices are moderated by circumstantial factors (2a & 2b):

2a). The correlation between symptoms of posttraumatic stress disorder and an individual's faith-based practices are moderated by social support factors.

2b)**.** The correlation between symptoms of posttraumatic stress disorder and an individual's faith-based practices are moderated by independent coping skill factors.

Method

Research participants will be sourced through the collaborating medical institution for this study. Medical groups such as RUSH, Northwestern Medicine, or OSF are of the medical institutions considered for collaboration. Existing or established patients with said medical

institutions who are currently or have recently received behavioral health or psychological healthcare services will be reviewed by medical staff. Upon review, patients who have been diagnosed with PTSD within the age range of 18 years old to 68 years old will be contacted via MyChart, telephone (call or text), email, or mail to inquire with them regarding their interest in research participation. Additionally, the medical institution may list details regarding the study on their webpage or encourage psychotherapists at their facilities to educate clients about the research participation opportunity.

Upon ensuring that participants meet the requirements for the necessary criteria to participate in the research study, they will be screened into the study by participating in survey style assessment. Survey research is the preferred method to collect baseline data for participants because asking questions to collect data directly from the research participant serves as a "snapshot of how people think and behave at a given time (Cozby & Bates, 2024)". Online through MyChart/patient portal, hand-out style (participant fills out the form independently in the medical establishment and returns the form before leaving), face to face and/or focus group interviews at hospitals, clinics, or other healthcare establishments within the institution may serve as effective modes of collecting baseline data from participants.

The clients will be required to answer survey questions by selecting an option that best represents their condition or experience based on the six-point scale outlined on the survey. Figure 1.1 outlines an example of how the baseline survey is intended to appear to collect accurate and consistent data across participants. Baseline data collected from the survey will be stored in an Excel spreadsheet and utilized to create a scatterplot graph to visualize the data. After the intervention, participants will take a similar six-point survey to analyze the effects of the intervention in comparison to those who were a part of the control group.

Figure 1.1 Participant Baseline Survey- PTSD/Faith-Based Practice 6-Point Scale

1. My current modality of treatment for PTSD addresses my spirituality or individual faith-based practice, regardless of religious affiliation.
    - ❑ Strongly agree
    - ❑ Agree
    - ❑ Undecided
    - ❑ Disagree
    - ❑ Strongly disagree
    - ❑ Decline to answer
2. Which of the following best describes your past involvement or connection with your faith-based practices, regardless of religious affiliation, before the onset of trauma/PTSD?
    - ❑ Affiliation with an organized religion/group
    - ❑ Personal spirituality
    - ❑ Faith-based in a religion but practiced independently
    - ❑ Belief or hope in a higher power (regardless of religious affiliation)
    - ❑ Atheist
    - ❑ None of these apply
3. How would you describe your clinical therapy involvement after the traumatization/PTSD diagnosis? (clinical therapy administered by a psychologist, licensed professional counselor, social worker, or other licensed mental health professional)
    - ❑ Never- I never received clinical therapy
    - ❑ Brief (less than 6 months)
    - ❑ Limited (6 months to 1 year)
    - ❑ Moderate (1 to 2 years)
    - ❑ Extended (2 to 5 years)
    - ❑ Prolonged (over 5 years)
4. Have you ever been medicated to manage any symptoms related to mental health/psychological symptoms?
    - ❑ Never- I never received clinical therapy
    - ❑ Brief (less than 6 months)
    - ❑ Limited (6 months to 1 year)
    - ❑ Moderate (1 to 2 years)
    - ❑ Extended (2 to 5 years)
    - ❑ Prolonged (over 5 years)
5. How would you describe your current involvement or connection with your faith-based practices, regardless of religious affiliation?
    - ❑ Affiliation with an organized religion/group
    - ❑ Personal spirituality
    - ❑ Faith-based in a religion but practiced independently
    - ❑ Belief or hope in a higher power (regardless of religious affiliation)
    - ❑ Atheist
    - ❑ None of these apply

The research design is intended to assess trauma intervention based on a pretest-posttest design mechanism. The data from the baseline survey will not determine which group the participant will be placed into. The pretest-posttest design model ensures that groups are equivalently distributed by numeric quantity. With each group containing equal numbers of participants, the design can have a higher likelihood of accurately portraying the intervention group outcome in comparison to the control group outcome. To ensure that participants are equivalently dispersed into the experimental and control groups, researchers will be administering a nonprobability sampling technique to analyze participant data based on age.

Since the pool for participant age is quite large, it is possible that probability sampling could unproportionally assign participants. This could lead to one group having far more participants at the younger age of the qualification spectrum than the other, thus resulting in skewed and inaccurate data. It is identified that there will be at least 50 people in both the experimental and control group. An even number of participants will be necessary to occupy both groups. Any less than 100 participants for the pretest-posttest design will require reformation of the design model, reconceptualization of the intervention, and redistribution of consent agreements to all current participants to ensure that they are still willing to participate in the research process.

During the intervention period, the control group will consist of at least 50 participants who will receive access to psychoeducational and supportive services as outlined during the intake. Both groups will receive these services provided by the medical institution that has collaborated with the study. The experimental group will receive additional interventions based on probability sampling. The options for intervention that the interventionist will participate in

are Eye Movement Desensitization and Reprocessing (EMDR) Therapy, Internal Family Systems (IFS) Therapy, and Cognitive Behavioral Therapy (CBT).

The intervention process will take place over 16 weeks, with each therapy intervention style being administered to the participant for a duration of 4 weeks during the 16-week duration of the intervention. The probability sampling will place participants from the experimental group into three subgroups: E1, E2, and E3. Participants will be distributed as equally by numeric quantity as possible into each subgroup. If there are 50 total participants, there would be 17 participants in two of the subgroups and 16 participants in the third subgroup. This should not impact the outcome data because the intervention is distributed to each participant individually for the same duration of time. By utilizing a Latin square technique to control order effects, each participant in the experimental subgroup will receive intervention in ordinance with the Latin square design. There are three conditions available for the three subgroups of intervention participants. Figure 1.2 outlines the conceptualized Latin square for these interventionists.

*Figure 1.2 Latin Square for Intervention Group Condition Determinant**

	Order of conditions		
	1	2	3
	EMDR	IFS	CBT
	IFS	CBT	EMDR
	CBT	EMDR	IFS

*E1, E2, & E3 will be placed on the left-hand side of the Latin square beginning with group E1 on the first row, followed by E2 on the second row, and finally E3 on the final or bottom row.

Some potential considerations for the function of the research design are not limited to the practical measures that have been in place to attempt to mitigate any potential disruptions during the research process. Although accounted for by careful and phrasing of survey questions, there is traditionally always a risk for bias or response set. When participants provide answers from a particular perspective rather than giving answers relative to the question (Cozby & Bates, 2024) it can skew data. Thus, we are reliant on participation data utilized for this research to be honestly put forth by the participants as a reflection of their legitimate experiences.

In addition, there are risks for the participant to take part in social desirability or answering question how they assume other participants might also answer the question. This does not give an honest answer to the participants' direct experience and can cause discrepancy in the data by leading to underreported undesirable behaviors. To account for this, there will be research personnel reviewing baseline data in part with weekly collected data from the interventionist group to analyze for any potential discrepancies and determine that participants are providing legitimate data.

Discussion

The design for this research was chosen based on the critical analysis of literature that is existing regarding PTSD and religiosity/faith-based practice. While a vast majority of data collection procedure is collected through interview and survey for non-veterans who have experienced trauma or have a PTSD diagnosis, there is little evidence available to support the survey research that has been done. This is largely in part of the online survey modality that was utilized by the researchers as the only means to collect data from their participants. There is much room for dishonesty and inconsistent results when the group is not controlled through models of selection for participation. By using the model created in this study, researchers will

have access to collaborate with healthcare providers at said medical institutions to ensure that the participants have legitimate intention or reasoning for being an effective participant.

Other modes of designs considered such as posttest-only or perhaps a Solomon four-group design would not best suit the modality of this research. While the posttest-only design would limit the ability to reflect on any potential changes that occurred within each group from the beginning of the intervention to the end of the intervention. A Solomon four-group design was considered more likely than the posttest-only due to its pretest and posttest design mechanism but proved to be better suitable for more dynamic research approaches regarding this topic. Since the study of PTSD in direct relation to faith-based practice is an uncommon research inquiry, it is most appropriate to keep the design simplistic, thorough, and conceptually understandable to analyze data without botching the potential for future research opportunities. Thus, future research may consider applying the Solomon four-group design methodology to attempt to replicate or disprove current research regarding PTSD and faith-based practice.

Ethical Considerations

There are ethical concerns regarding the process of requesting candidates to self-disclose specific personal life details to be considered as a potential participant. The privacy that surrounds their personal life is being shared with strangers who are using their experiences to better understand science, which can feel invasive, unfamiliar, and uncomfortable to the candidate. While the candidates' private information will be stored securely and their identities will remain confidential, there are emotional dysregulations that may be provoked as researchers inquire about their trauma. Encouraging someone with a trauma-related disorder to describe their trauma can bring up unwanted suppressed feelings and trigger forms of psychological or physiological distress. Presenting these subjects with appropriate clinical methods of therapeutic conversation may help mitigate, reduce, or support participants as they share their stories.

However, the participants' psychological and physiological wellbeing must be monitored and tracked throughout the duration of the study to ensure their safety.

Access to medical records will require the participant to understand how their data is used, protected, and stored. Data will need to be authorized by the participant through signature before sharing confidential information with researchers. The participant has the right to withdrawal their status as an active participant at any time after consenting. In the case of withdrawal, researchers remain authorized to use data provided during the period of consent to which the medical records are used as reference. All other medical records that are irrelevant to the withdrawn participant will be discarded in compliance with The Health Insurance Portability and Accountability Act (HIPAA).

Regardless of the agreement and former levels of inquiry, participants may reach a point in the study where they are asked to disclose their history of clinical treatment, details about the traumatic event, explanation of their faith-based practice or religious history, and other details about their lives. Participants will be made aware of these questions as a component of the study before consenting, however, the discomfort that may arise during interviews could complicate their participation. How the researchers respond to the participants' discomfort is a critical component of the research design. Therapists must be available to provide intervention in the case that a crisis unfolds prior to, throughout, or any time after an interview. The consideration of whether leading participants to engage in conversation that requires their recollection of traumatic events can raise ethical concerns, but with proper care and due diligence participants can remain safe throughout the process.

Legal ethics are a component that will be a topic of inquiry before beginning the study and reassessed as the study progresses. Ensuring that the participant’s traumatic details of their

story are not tied to legal confidentiality is essential. Each candidate will be required to consent to a background check prior to their active participation. Additionally, participants are expected to remain clear of criminal misdemeanor or felony offenses. In the event of a criminal misdemeanor or felony charge, the participant will be discharged from their participation in the research study. In the case of any information shared by the participant for the sake of research is subpoenaed under law, the information may be disclosed to law enforcement officials under appropriate and ethical circumstances that are in accordance with HIPAA. Participants who have legal concerns that are personal or those of a loved one involved in their trauma story are advised to consider the extent of their participation and self-disclosure prior to their involvement in the study.

Information shared with researchers under consensual agreement for research participation cannot be revoked under any circumstances. This may serve as an ethical concern for the participant as what they say in their interviews cannot be redacted. To mitigate any potential of exploitation, candidates will be required to participate in a set of cognitive examinations and exercises that will assess their mental fitness or capability to self-disclose, regardless of them possessing self-guardianship. After a candidate is cleared to provide informed consent, they will be reminded of their rights before each interview as a participant.

While the ethical considerations that have been outlined are not the full scope of concerns that could possibly arise during the research process, the team working on this study will provide constant redetermination of ethical adherence to ensure the safety of our participants. The mission of the research is to help the participants share their story and be able to actively work though the trauma as they help deepen their understanding of their problems. With this,

researchers can understand the impact of treatment methods for posttraumatic stress disorder as well as uncover details about the question and hypothesis that guides the study.

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