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Therapeutic Aspects of Tattoo Acquisition: A Phenomenological Inquiry into the Connection Between Psychological Trauma and the Writing of Stories into Flesh

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Therapeutic Aspects of Tattoo Acquisition: A Phenomenological Inquiry into the Connection Between Psychological Trauma and the Writing of Stories into Flesh

A Dissertation Presented for the
Doctor of Philosophy
Degree
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Everett W. Painter
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Dedication

To all survivors of psychological trauma. Your courage and perseverance are a testament to the human spirit.

"Traumatic events are extraordinary…they overwhelm the ordinary human adaptations to life…" (Herman, 1997).

Acknowledgments

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Abstract

Since the start of recorded history, accounts are replete of individuals being subjected to unthinkable experiences that possess the power to fundamentally disrupt their lives. Survivors of psychological trauma encounter numerous obstacles on the pathway to recovery (Briere & Scott, 2015). Counselors working with this population continue to search for effective strategies in support of restoration (Boxer & Sloan-Power, 2013). One possibility often discussed by trauma survivors in popular media as helpful is tattoo acquisition. However, our understanding of this body modification practice is incomplete due to a social history of stigma and bias (Stein, 2011). The purpose of this study was to explore the ameliorative and therapeutic factors of tattoo acquisition for adult survivors of trauma. Hermeneutic phenomenology was selected as the means for interpreting the lived experience of six trauma survivors who acquired tattoos directly related to their traumatic life events, against a theoretical background informed by Herman's (1997) stage model of recovery. Several themes emerged relative to this relationship indicative of a thoughtful expressive act, meaning construction, reclamation of control, calming comfort, and precipitator of growth. These themes represent new knowledge regarding the connection between trauma survivors and the use of tattoos. In essence, tattoo acquisition for these participants facilitated movement from a state of brokenness to one of evolving wholeness. The significance of these findings include contributions to our understanding of this practice that may lead to creative interventions for addressing human suffering and the unique needs of trauma survivors. They also serve to help move the topic of tattooing away from a solely deviant discourse. Implications for both counselors and counselor educators are discussed. Recommendations for future research are also outlined.

Keywords: psychological trauma, tattoos, therapeutic, counselor education, hermeneutic phenomenology

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Chapter One: Introduction

Psychological Trauma

Mental health developments, social attitudes, and political influence inform the rich history of psychological trauma. While there is still disagreement about what constitutes a traumatic experience, the most widely used definition explains trauma as an event or situation in which an individual experiences fear, helplessness, or horror (American Psychiatric Association [APA], 2013; Jones & Cureton, 2014). The threat of serious injury or death may be real or imagined (APA, 2000). Having a clear understanding of traumatic events is important for counselors because they have significant exposure to its impact in work with clients. Some surveys suggest that more than half of all adults in the United States experience a traumatic episode (Briere & Scott, 2015). Similarly, researchers noted in current mental health settings, it would be unusual to find a client free of trauma experience (Gantt & Greenstone, 2016).

Trauma occurs in many ways and along a continuum relative to severity and complexity (Jones & Cureton, 2014). Some of these include sexual abuse, domestic violence, school or work related violence, natural disasters, and war violence. Individuals exposed to these events are regularly encountered in clinical settings (APA, 2013; Briere & Scott, 2015; Trippany, White Kress, & Wilcoxon, 2004). A review of statistics underscores the ubiquity of potential trauma-causing events. First, the Federal Bureau of Investigation (2014) reported over one million violent crimes (including murder, rape, robbery, and assault) nationwide in 2014. Second, relative to natural disasters, ten weather events in the United States in 2015 exceeded the billion-dollar level in losses and resulted in 155 deaths. In fact, an average of 5.2 instances of this event category occur annually (National Centers for Environmental Information, 2016). Third, global incidents of terror are increasing. In 2014, deaths were up 80 percent over the previous year,

occurred in 67 countries, and numbered 32,685 worldwide (Institute for Economics and Peace, 2015). Global military operations related to this terrorist activity and other issues further result in trauma exposure for those individuals. Military personnel include war veterans who often experience a variety of related struggles, including PTSD symptomatology (APA, 2013; Wood, 2013). Finally, societal prejudice and racism contribute to intergenerational experiences that may result in trauma (Sommer, 2008). This data in part supports the assertion that "...counselors in virtually all settings work with clients who are survivors of trauma" (Trippany et al., 2004, p.31).

Trauma Survivors

Researchers noted a variety of responses to trauma and observed typical behaviors indicative of reasonable attempts to handle overwhelming scenarios (Dubi & Sanabria, 2010). However, these normal reactions may become pervasive and deeply troublesome for the survivor (Briere & Scott, 2015). Negatively impactful reactions to trauma stem from the loss of control embodied in extreme, helpless, and catastrophic experiences (Herman, 1997). While specific reactions vary between individuals, shared survivor experiences include: 1) hyperarousal or a sense of always being on guard against potential threats, 2) intrusion in the form of continual disruption by way of memories or flashbacks, 3) constriction or a numbness to life, 4) emotional regulation problems (shock, dissociation, hopelessness), 5) disconnection from or damage to interpersonal relationships, 6) somatization or the manifestation of physical symptoms (fatigue, hyper-arousal, headaches), 7) cognitive distortions (confusion, impaired thinking, questioning of values), and 8) altered perceptions and beliefs (Herman, 1997; Herman, 2014; Mejía, 2005; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014a). In summary, survivors of trauma may experience many troublesome symptoms with the potential to disrupt quality of life in significant ways.

These experiences will sometimes become overwhelming for the survivor and lead to long-term conditions such as depression, anxiety, Acute Stress Disorder (ASD), Post-Traumatic Stress Disorder (PTSD), or other emotional difficulties that reduce wellness and normal daily functioning (Briere & Scott, 2015; Dubi & Sanabria, 2010). Ultimately, numerous personal characteristics such as age, gender, and cultural factors must be evaluated to determine person-specific patterns and overall impact to the survivor (Mejía, 2005; Briere & Scott, 2015). Such complexity makes work with trauma tangled and difficult. Yet, this attention to detailed assessment is necessary as trauma may have a negative impact on all areas of functioning (Dass-Brailsford, 2007).

Another feature often present is the need to tell one's story (Ricks, Kitchens, Goodrich, & Hancock, 2014). Human beings have a natural tendency to story tell in a way that provides structure and meaning for experiences (Joseph, 2011). Each trauma survivor has a unique story related to the impact of the experience(s) (Marzillier, 2014). Relative to post-trauma intervention, these narratives function to assist survivors in interpreting and understanding their experience (Joseph, 2011). The need to make meaning from events is reflected in all the major stage models of trauma recovery. Each emphasizes the integration of this meaning-making as an important end stage marker in cases of successful resolution (Dass-Brailsford, 2007). In summary, individual meaning-making or meaning reconstruction is a central concern for trauma survivors on the road to recovery.

Post-Traumatic Growth

Given these common responses, it is unsurprising that a wealth of research focuses on negative aspects of the trauma experience (Ben-Porat & Itzhaky, 2009). Suffering is a common experience in life. While this knowledge is useful relative to clinical understanding of such

experiences, there is a need for information about how to best assist clients with coping. Researchers recognize a recent trend in trauma research involves a focus on the potentially beneficial aspects of significant, aversive events in their aftermath (Weiss & Berger, 2010). Several factors precipitating this trend included increased terrorist activity in multiple world regions, regular occurrences of natural disasters, and the emergence of positive psychology along with increased prominence of the wellness perspective within the mental health field (Altmaier, 2011; Weiss & Berger, 2010). The term *post-traumatic growth* first appeared in the literature in 1995 and acknowledged that growth, and even transformation, may occur for survivors of traumatic events (Calhoun & Tedeschi, 2013; van Dernoot & Burk; 2009). Furthermore, Hernandez-Wolfe, Killian, Engstrom, and Gangsei (2015) explained that trauma work is both difficult and joyful while offering insight into how individuals handle the adversities of life. Such refocusing provides clinicians with a perspective of hope and change for clients. Thus, the provision of counseling services with trauma survivors presents the opportunity to help increase functioning and well-being moving forward (Altmaier, 2011).

Introduction of Theoretical Framework

A variety of models exist for understanding the progression of trauma responses in survivors. Many of them are highly congruent regarding outcome focus and may be used interchangeably given these similarities (Dass-Brailsford, 2007). For the current project, I selected Herman's (1997) stage model. Her framework suggests that safety, remembrance and mourning, and reconnection are critical to the process of recovery. These last two stages focus on reintegration and emphasize the relational work necessary for forward movement and improved functioning (Dass-Brailsford, 2007; Herman, 1997).

In session, the counselor becomes a witness and consultant relative to the material discussed (Herman, 1997). During the process, a counselor may take on several dispositions including acting as an ally, avoiding attempts at rescuing, promoting control on the part of the client, acting as a coach, fostering empowerment, offering encouragement, and managing reconnection attempts (Dass-Brailsford, 2007). This relational and exploratory context may be particularly relevant when paired with narratives related to the acquisition of tattoos. Exploration of survivors' unique stories and meaning-making narratives may be considered essential aspects of the mourning and reconnection stages. Counselors utilizing this framework take care to work collaboratively with clients, allowing them to construct new meaning free of assumptions and judgment (Herman, 1997).

While these stages do not always unfold linearly as presented, they do represent the major areas that must be traversed and reconciled by trauma survivors on the pathway to recovery. In a sense, a survivor's relationship with events is transformed (Herman, 1997). This process allows a person to deal with the trauma experience in an adaptive way, with a better understanding of self and improved overall life function.

Therapeutic Interventions with Trauma Survivors

Many theories, values, and assumptions exist informing therapeutic work with trauma survivors (Marzillier, 2014). Broadly, responses should provide conditions inclusive of, 1) safety, 2) trustworthiness, 3) support, 4) collaboration, 5) empowerment, and 6) consideration of cultural, historical, and gender issues (SAMHSA, 2014b). All these qualities support and are represented throughout Herman's (1997) recovery model. Specific clinical approaches emphasized in the literature include cognitive behavior therapy (CBT; Kar, 2011; Rothbaum, Meadows, Resick, & Foy, 2000; SAMHSA, 2014b; Tran & Gregor, 2016), exposure therapy

(Chard & Gilman, 2005; Foa, 2009; Makinson & Young, 2012; Resick, Nishith, Weaver, Astin, & Feuer, 2002), Eye Movement Desensitization and Reprocessing (EMDR, Chard & Gilman, 2005; Shapiro, 2001; Shapiro & Maxfiled, 2002), narrative therapy (Beaudoin, 2005; Carey, 2013; Neimeyer, 2009; Sahin & McVicker, 2009; Schauer, Neuner, & Elbert, 2011), and a variety of other methods falling within the cognitive-behavioral framework (Dass-Brailsford, 2007). Research into these approaches lend support to Herman's (1997) recovery model, and connections are made in Chapter Two. Expressive arts applications are a more recent development. These strategies focus on meaning-making and alternate ways to process and express difficult experiences, lending themselves to a connection with post-traumatic growth.

Expressive Arts in Counseling

There is a small but growing body of research demonstrating the effectiveness of artistic interventions with trauma clients. This is especially true of children, who often do not have the vocabulary necessary to verbalize their experiences, and adults who find a traumatic event too difficult to put into words (Carey, 2006). Other researchers suggested the use of expressive arts with trauma survivors has an overall calming effect, assists clients in expressing their experiences, results in benefits even after counseling has terminated, and helps facilitate the use of negatively impacted cognitive areas through storytelling (National Clearinghouse on Families and Youth [NCFY], 2013). For example, Gantt and Greenstone (2016) illustrated the use of narrative art therapy in the case of a woman raped and held in captivity. They explained the medium of art on paper allowed the client to tell her story in a way she was unable to previously, allowing for processing, and ultimately resolution. Expressive writing may be used with clients as well (Marzillier, 2014). More recently, an approach coined *trauma-informed expressive arts*

therapy has emerged which integrates sensory aspects of the arts with neurodevelopment (Malchiodi, 2012).

Gladding (2011) asserted, "…the arts foster different ways of experiencing the world. They are enriching, stimulating, and therapeutic. When used in clinical situations, they help counselors and clients gain unique and universal perspectives on problems and possibilities" (p. viii). The expressive arts encompass many forms including visual, drama, music, writing, and dance. Researchers noted the universality of art, its effectiveness with diverse populations, and the ability of a clinician to be able to modify interventions as needed (Degges-White, 2011; Gantt & Greenstone, 2016). This unique implementation of arts in counseling is useful relative to creative and innovative methods in support of client expression and problem-solving as they work to improve functioning (Degges-White, 2011).

Tattoo Acquisition

While tattooing is not considered in the literature as an expressive art in the traditional sense, the practice is widely regarded as a genuinely artistic expression (Schwab, 2015). Such use allows for a focus on expression and unique experience (Gladding, 2011). Tattoos are not a new phenomenon. This practice of body modification has existed for centuries (Mantell, 2009; Wohlrab, Stahl, & Kappeler, 2007; Sanders, 1988). A recent poll found three in ten (29%) Americans have at least one tattoo (The Harris Poll, 2015); a number that continues to rise. Prevalence is higher in younger groups as evidenced by 47% of Millennials having at least one. Still, tattoos have a checkered history within a social context often characterized by stigma and negative stereotypes (Caplan, 2000). While these stereotypes seem to be on the decrease, of poll survey respondents without tattoos, 45% felt tattoos represented rebelliousness, 47% found

tattooed individuals less attractive, and 29% equated those with tattoos as less intelligent (The Harris Poll, 2015).

As with the traditional public opinion regarding tattoos, bias and negative views are present within the research community. In the past, the mental health field often correlated tattoos with deviant behavior, criminality and other psychological issues (Kosut, 2006; Mantell, 2009; Stirn, 2003; Stirn & Hinz, 2008). Stein (2011) suggested tattoos have a history of stigma and pathology associated with behavior such as aggression, sexual fetishism, and general instability. This view is shifting with the recognition that tattooing enjoys increased cultural acceptance, is becoming a more mainstream practice across multiple social groups, and has gained positive attention within the art world (Goulding, Follett, Saren, & MacLaren, 2004; Mun, Janigo, & Johnson, 2012; Sanders, 1988; Stein, 2011; Stirn, 2003). Popular culture supports this view through the proliferation of specialized magazines, tattoo shops and numerous television programs such as *Miami Ink* and *Ink Masters*.

A paucity of data exists regarding the psychological aspects of tattooing (Stirn, 2003), especially as it pertains to trauma. Most recent studies in this area examined the memorial tattoo (Gentry & Alderman, 2007; Mantell, 2009; Sarnecki, 2001). A memorial tattoo is typically obtained to remember a deceased loved one or another significant life event. Attention focused on those acquiring tattoos to support family member survivors of the Holocaust and those who lived through Hurricane Katrina (Gentry & Alderman, 2007; Rudoren, 2012). Other investigations explored the numerous meanings and motivations associated with being tattooed (Mantell, 2009; Heywood, Patrick, Smith, Simpson, Pitts, Richters, & Shelley, 2012; Tiggemann & Hopkins, 2011; Wohlrab et al., 2007). Fewer studies made a direct link between trauma and the acquisition of tattoos. However, some researchers do make a connection between tattoos and

trauma coping (De Mello, 2000; Hewitt, 1997; Liu & Lester, 2012; Stirn, Oddo, Peregrinova, Philipp, Hinz, 2011; Wohlrab et al., 2007). Woodstock (2014) argued reality television is emerging as a place to witness the intersection of tattoo culture and therapeutic narratives. Many shows now follow the stories of people getting tattoos as they explain their significance. Gentry and Alderman (2007) suggested trauma survivors need to be seen, need to tell their story, and may respond by permanently inking aspects of their story into their skin. Possible reasons for the limited research in this area include privacy concerns and survivor apprehension about discussing experiences (Stirn & Hinz, 2008).

Given the issues in previous tattoo oriented research, what we know about them and their general relationship to aspects of mental health is limited and biased. Tattoos are often filled with meaning for the recipient and memorial tattooing is a relatively common practice (Atkinson, 2013). The prevalence of both trauma and body modification in modern society provides an opportunity to explore their connection and possible contributions to existing theories of trauma recovery.

Statement of the Problem

Relative to trauma survivors, tattoos may serve as a permanent, visual reminder (Trachtenberg, 1998). They provide a personal and public means of expressing memories and feelings (Gentry & Alderman, 2007). Tattoos may also be a statement about regaining control (Rohrer, 2007). For example, Wohlrab et al. (2007) identified personal narratives that encompassed catharsis and body reclamation as primary factors. Sarnecki (2001) explained that tattoos might help trauma survivors creatively manage parts of an event that remain unresolved. She concluded, "…a tattoo becomes a way to understand and incorporate a physical and psychological loss while regaining some sense of control and a new sense of empowerment" (p.

37). As discussed in Chapter Two, tattoos are imbued with meaning and authors speculate about their utility, yet the role they play with trauma survivors is unclear.

Others suggested that tattoos may serve as an indicator of our ideal selves and that we may even change our behavior to be congruent with the meaning we associate with them, but our understanding of these processes is limited (Mun et al., 2012). While tattooing has become a much broader practice and holds significance for recipients, such recognition and understanding are undermined by misinformation that may still be associated with tattoo acquisition (Kang & Jones, 2007; Kjeldgaard & Bengtsson, 2005). Additionally, we know expressive arts help assist survivors to make meaning of their experiences (Carey, 2006; Malchiodi, 2012). However, the relationship between trauma, survivor coping, therapeutic interventions, and tattoo acquisition has not been investigated in the literature. Given both the prevalence of trauma and tattooing in our society, more research is needed to examine these possible connections.

Purpose of the Study

The purpose of this phenomenological study was to contribute to the understanding of the ameliorative and therapeutic factors of tattoo acquisition for adult survivors of trauma. Tattoos as a research topic have received little attention, in part due to negative stereotypes and association with mental health issues (Mun et al., 2012). Such positioning limits our understanding of their utility beyond simple artistic statements. However, tattoos can be significant to those who receive them (Sanders & Vail, 2008). This study explored the meaning and possible therapeutic properties they possess for survivors of traumatic events, along with connections to various interventions that align with Herman's (1997) recovery model.

Research Questions

The nature of this study was exploratory. Variables included, 1) body modification (tattooing) – inscribing symbols, words and other features on the skin, 2) the meaning people associate with those tattoos, and 3) therapeutic factors – having a beneficial effect on one's mental state, health or coping. The primary research questions were:

R1: As an adult survivor of trauma, what is the lived experience of obtaining a tattoo?

R2: How is tattoo acquisition beneficial relative to survivors' traumatic experiences?

Significance of the Study

Gentry and Alderman (2007) observed, "…we must be open to the seemingly little things if we are to understand the full breadth of how individuals reveal their identities and experiences to others" (p. 195). Counselors in all settings encounter survivors of trauma and the practice of tattooing is becoming mainstream. People are motivated to get tattoos for many reasons and they hold deeply personal meanings. This meaning may have natural connections to expressive arts and other approaches used in counseling. Yet, there are little data regarding the psychological aspects of tattooing (Stirn, 2003). A secondary impact will be the repositioning of tattoo research away from deviant discourse so we may more fully understand their utility. Knowledge regarding trauma survivors' utilization of tattoos to help them cope with their experiences may be highly useful to counselors working with such populations. Findings will contribute to the existing body of knowledge related to topics such as trauma coping, tattoo meaning, and counseling interventions with trauma survivors. Such understanding may impact counselor training and provide counselors with an additional means for understanding their clients while suggesting potentially creative therapeutic avenues to explore.

Definition of Terms

Trauma: Broadly defined, trauma represents an alarming event or experience. The threat of danger (serious injury, death, sexual violence) may be real or imagined. The exposure to the experience may occur in four ways including: 1) direct exposure, 2) witnessing, 3) learning of the experience of a close friend or family member, or 4) repeated exposure to event details. The experience may have a disruptive and long lasting impact on functioning, attitudes, and behavior (APA, 2013; American Psychological Association, 2015).

Trauma Survivor: A trauma survivor is a person who has directly or indirectly experienced a deeply disturbing event or experience. There is often a need to share accounts of the experience. Thus, a narrative is shaped and constructed by the survivor and is thought to be a cognitive and developmental process (Tuval-Mashiach, Freedman, Bargai, Boker, Hadar, & Shalev, 2004). In best case scenarios, and in collaboration with a counselor, trauma survivors can explore their experience, create associated meaning(s), and actively author their stories going forward.

Post-Traumatic Growth: Post-traumatic growth is the recognition that survivors of traumatic experience may experience significant growth following the experience. Further, emphasis is placed on this growth within the therapeutic context along with de-emphasizing formal diagnosis. This notion rests on the belief that personal growth is a result of dealing with adversity (Joseph, 2011; Joseph & Linley, 2008; Calhoun & Tedeschi, 2013).

Expressive Arts in Counseling: The use of expressive arts is a counseling approach utilizing arts such as music, dance, writing, etc. as part of the therapeutic intervention. These mediums are used to help facilitate communication and expression while encouraging self-awareness and wellness (American Psychological Association, 2015). Clients do not need artistic ability to benefit.

Tattooing: Tattooing is a form of body modification achieved by inserting colored ink by the tapping of needles (or with a machine) into the dermis layer of the skin (Hudson, 2009). Designs may be simple or elaborate ranging from words or symbols to full-body works of art. They often represent aspects of personal identity and social communication (Atkinson, 2003).

Delimitations

This study used a purposeful sampling method and sought adult (18 and older) participants who utilized the practice of tattooing to help them cope with their traumatic experience. Participants were recruited in a mid-size Southeastern city and surrounding communities. The primary means of study notification were discussions with gatekeepers (tattoo shop owners) and community advertising. Trauma constitution or elements were not defined by the researcher. This was an intentional choice given individual experience, perception, and recognition that the way we each define trauma varies. Thus, participant experiences may have potentially included loss of a loved one, mental and physical illness or events, natural disaster, significant life events (i.e., rape), etc. Finally, the researcher excluded potential participants still within a twelve-month window following their traumatic event. This helped to reduce any interference with safety or stabilization work.

Limitations

This study was naturalistic and exploratory in nature. These same qualities also served as the primary limitation. It is recognized that generalizability of findings to a wider population is difficult given the nature of the study. A study sample of only women posed the primary limitation for the study and is discussed later. The purposeful sampling method used limits the applicability of conclusions beyond these participants. However, it was important to explore the research question in depth and this sampling procedure ensured that participants were

appropriate as they had direct experience with the questions under investigation. Additionally, all scientific research is considered tentative, as new findings update or replace current understanding. This is particularly the case in phenomenological studies as we investigate what is becoming, thus never allowing for findings to be final (Vagle, 2014). However, this area is one of limited research and it is hoped findings will lead to more focused questions and directions for further investigation. Another limitation was the potential for researcher bias. Efforts to identify and limit the impact of personal assumptions were undertaken and are discussed in Chapter Three. Finally, some resistance was encountered relative to recruitment of participants. During a pilot study, a gatekeeper informed me researchers in the tattoo community are often met with hesitation and skepticism given negative past experiences and feelings of being stereotyped. I found this to be accurate.

Organization of Study

This study is organized into five chapters. Chapter One focuses on an introduction to the topic of this investigation. This includes an overview of relevant constructs, definitions, and a brief explanation regarding the importance of the study. Chapter Two details the literature regarding trauma, trauma counseling, tattoo acquisition, and other salient concepts. Chapter Three provides an explanation of methods used. This includes the positionality of the researcher, a detailed description of participants, an examination of phenomenological methodology, and steps utilized for data analysis. Chapter Four presents results and interpretation of the data. Finally, implications for counselors are discussed in Chapter Five along with recommendations for future research.

Chapter Two: Review of the Literature

An overview of the history, literature, and context that informs this work is necessary to ground and provide direction for the research. While it is not the intent of this chapter to provide a full review of the literature relative to trauma, I cover an extended description of the available literature relative to the primary constructs being investigated to help understand the purpose of this project. Research began by reviewing published studies in flagship journals of the counseling profession before expanding into related mental health areas such as psychology and social work. Finally, I completed a wide search of behavioral science databases using search terms related to the primary constructs (i.e., trauma, trauma survivor, trauma counseling, etc.). This search revealed two important points, 1) much of our trauma knowledge is based on studies of PTSD or symptoms related to that diagnostic criteria and 2) while a wealth of research on trauma exists, available literature originating from the counseling profession is more limited and scattered. As the population of this study consists of adults, a review of the literature on childhood trauma was excluded except in instances where no adult examples existed.

First, I provide a brief historical perspective on the development of psychological trauma. Second, I explore emotional and other consequential aspects of the trauma experience for survivors, followed by a review of treatment literature arranged according to Herman's (1997) three stage recovery model. Third, since the focus of counseling trauma survivors is coping and restoration of functioning, I examine the notion of post-traumatic growth. Finally, tattooing as a form of expression along with its history and connection to traumatic experiences is explained.

Psychological Trauma: A Historical Perspective

Psychological trauma, like most established mental health issues, is a social construction as evidenced by numerous changes to its diagnostic criteria over time (Scott, 1990; Weathers &

Keane, 2007). While several definitions exist, trauma is currently viewed within the therapeutic community as "a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2). A salient feature of these extreme events is the resulting need to cope with the new and unexpected (APA, 2000). The U.S. Surgeon General (1999) described trauma as a significant public health risk and priority. It is important to note that due to complexities, a single definition of trauma is difficult to develop (Garrido, Baker, Davidson, Moore, & Wasserman, 2015; Weathers & Keane, 2007). Thus, a thorough understanding of the context of this study cannot be achieved without first examining the rich social, developmental, and psychological history that informs the modern conceptualization of psychological trauma. Attention to the clinical aspects of trauma developed in fits and starts as researchers strived to understand the scope of life-changing events and our subsequent reactions (Courtois & Gold, 2009; Herman, 1997). A brief review of the conceptualization of psychological trauma is necessary to understand where we currently stand.

Trauma has been part of the human experience since the dawn of time. Derived from the Greek word for "wound", evidence of struggles with life-changing events may be found throughout the written record (Jones & Cureton, 2014). Yet, misdirection and other ramifications that complicate the ability to reach even the most basic consensus confounds our understanding of the emotional reactions and consequences of trauma (Weathers & Keane, 2007). The first accounts of an attempt to understand the internal impact of traumatic experiences are found in late 19th century writings of Pierre Janet and Sigmund Freud (Courtois & Gold, 2009; Jones & Cureton, 2014; Wilson, 1994). Both developed theories about the behavioral consequences of

traumatic events and labeled the resulting symptoms *hysteria,* a condition marked by reactions to some significant event no longer in memory, but result in altered states of consciousness (Gentry & Baranowsky, 2002; Herman, 1997). Janet referred to these states as *dissociation* (Gentry & Baranowsky, 2002) and observed they lack logic and sensibility (van der Kolk, van der Hart, & Bugridge, 1995). Freud's elaboration on hysteria formed the basis of his seduction theory as he surmised the dysfunction he witnessed in his patients was the direct result of childhood sexual abuse (Wilson, 1994). Freud himself would later abandon this singular explanation largely due to further insight into the practicalities of what his theory implied; rampant sexual oppression of women and children within Victorian society (Herman, 1997; Wilson, 1994). Critics at the time also condemned his ideas due to their sexual nature (Courtois & Gold, 2009), which went on to diminish social attention on the issue. Others would later add their rebuke of such explanations as attempts by men to label aspects of women's behavior they did not understand (Micale, 1989). Many of Freud's idea still impact modern mental health theory and practice. This is true of our understanding of trauma as well. But because of the negative reaction at the time, the focus on trauma waned before resurfacing again during times of war.

The First World War placed a large public spotlight on the psychological impact of life-changing events. Exposure to the atrocities of the war experience resulted in men exhibiting a variety of symptoms resembling the hysteria patients mentioned above: screaming, uncontrollable weeping, states of catatonia, memory loss, inability to feel, and general unresponsiveness (Herman, 1997). This constellation of symptoms was dubbed 'shell shock' and efforts were undertaken to pinpoint a physical cause (Jones & Wessely, 2006; Scott, 1990). Some estimates suggested mental difficulties represented as much as 40% of the casualties for the British military (Herman, 1997). Such incidents were largely attributed to general weakness

or cowardice (Webber, Mascari, Dubi, & Gentry, 2006). Consequently, attention was demanded to investigate this population and devise a strategy for rehabilitation and ultimately a return to the battlefield (Jones & Wessely, 2006; van der Kolk et al., 1995). In the face of political resistance, mental health professionals in the military conceded that these issues were due to psychological trauma and the sustained emotional stress of war (Herman, 1997; Jones & Wessely, 2006). Interest in the internal impact of trauma again subsided following the war and left in its wake a population of men with lingering mental health problems sidelined as "…their presence had become an embarrassment to civilian societies eager to forget" (Herman, 1997, p. 23).

Interest in trauma once again heightened at the start of World War II and by this time, a growing understanding that traumatic events could lead to emotional issues existed (Herman, 1997). Still, to subvert a reoccurrence of 'shell shock' as seen previously, the term was made illegitimate, bringing along with it an announcement that cases of mental injuries would result in the loss of war pensions (Jones & Wessely, 2006). While there was an effort underway to understand specific war conditions and their impact (Herman, 1997), a directive was enacted to classify military personnel exhibiting mental issues as exhausted, thereby diminishing the perceived seriousness of the issue and implying only rest was needed as treatment (Jones & Wessely, 2006). Although much research was conducted during and immediately following the war (Herman, 1997), attention on this topic once again subsided (Jones & Cureton, 2014). Military psychologists were aware that war conditions had a significant impact on soldiers, but the push to diminish and ultimately disregard this impact over politics and worry of perception hampered the recognition, understanding, and treatment of trauma.

One important development of World War II for trauma survivors was the recognition that *anyone* could succumb to the pressure of war (Webber et al., 2006; Scott, 1990); a push to remove stigma and acknowledge that the quality of specific experiences play a significant role relative to subsequent mental health consequences (Herman, 1997). Attention again peaked during the Vietnam War and ushered in a sustained focus on the trauma experience (Courtois & Gold, 2009; Jones & Cureton, 2014). Soldiers developed a variety of issues including violent outbursts, nightmares, substance abuse, and relationship problems (Webber et al., 2006). The combination of anti-war movements and a new observation of delayed symptoms in veterans returning home spurred further examination (Jones & Wessely, 2006). Largely due to the social and political climate of the time, the pain experienced by trauma survivors became a topic that could no longer be ignored, and the challenges experienced in the face of atrocity gained legitimacy by their inclusion in the third revision of the Diagnostic and Statistical Manual (DSM) as Post Traumatic Stress Disorder (Herman, 1997; Scott, 1990; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). PTSD diagnostic features indicate a negative, systemic impact on thoughts, feelings, and behaviors (Wilson, 1994). The recognition and inclusion of this diagnostic criteria ended decades of suppression related to the impact of human suffering in the face of trauma.

The placement of trauma in the DSM represented a long history of development by mental health professions and reflects our social context, diagnostic challenges, and transitioning perspectives. Reactions to stress were recognized in the first two editions of the DSM, most notably as ‘gross stress reaction’ in the DSM-I (APA, 1952), later evolved to ‘adjustment reaction to adult life’ and joined by ‘transient situational disturbance’ in the DSM-II (APA, 1968). However, such conditions implied that symptoms would abate in the absence of the

distressing event or situation (Scott, 1990; Yehuda & Bierer, 2009). The DSM-III recognized trauma as occurring "…outside the range of usual human experience" (APA, 1980, p. 236). This acknowledgment served to validate the serious and potentially damaging nature of such experiences (Jones & Cureton, 2014). However, the inclusion of PTSD diagnostic criteria in the DSM was not without controversy due its highly political background (Scott, 1990), but became a widely accepted and developed diagnosis despite the lingering questions regarding its core assumptions and our ability to define a universal trauma reaction (Jones & Wessely, 2006; Weathers & Keane, 2007).

The DSM-IV (APA, 1994) and DSM-IV-TR (APA, 2000) continued to expand the definition of trauma by including events such as marital discord, car accidents, and the deaths of loved ones. This more encompassing definition led to a significant increase in trauma diagnoses (Breslau & Kessler, 2001). The development also led to concerns of PTSD being over-diagnosed and increased debate about what constituted a traumatic experience for individuals (Brewin, Lanius, Novac, Schnyder, & Galea, 2009; McNally, 2009). The conceptualization of trauma continues to evolve and in the most recent DSM-5 (APA, 2013), PTSD became part of a larger classification of disorders, Trauma and Stressor Related Disorders (TSRD), with several changes made to the diagnostic criteria. Creating a separate chapter outside anxiety disorders increased importance on exposure to a traumatic event, expanding the realization that such events may be deleterious to overall mental health (Jones & Cureton, 2014).

Early theories of hysteria and investigations into the impact of war form two major streams of inquiry into the nature of psychological trauma. In fact, much of the available theoretical and conceptual knowledge are informed by studies examining reactions to war, namely PTSD or considered more broadly, the stress response (Jones & Cureton, 2014; Weathers

& Keane, 2007; Wilson, 1994). More recently, the impact of the Women's Liberation Movement became a third. With an expanding acceptance regarding the nature of trauma causing events, sexual and domestic violence against women and children was brought into the open (Courtois & Gold, 2009; Herman, 1997). Attention during this time also returned to Janet's idea of dissociation to help account for symptoms experienced by survivors of childhood sexual and physical abuse (Courtois & Gold, 2009). This widened scope on interpersonal violence was a significant factor in the DSM-III PTSD and dissociative disorders development (APA, 1980; Courtois & Gold, 2009; Jones & Cureton, 2014). It appeared that symptoms experienced by rape and child abuse survivors for example, were like those experienced by soldiers (Webber et al., 2006). Fear and shame supported an environment conducive to sexual oppression. Women suffered with many of the same traumatic symptoms as those exposed to war violence, but in silence. At the same time, research into sexual assault saw a drastic increase, helping to bolster public attention on sexual violence (Herman, 1997).

Today, we recognize there are no limitations regarding the experiences that may lead to troubled mental health. Socially, the skepticism of previous generations has been replaced with compassion (Fassin & Rechtman, 2009). And trauma as a topic of study appears to have broad support and continuity, no longer punctuated by long periods of absence due to social disinterest (Courtois & Gold, 2009; Herman, 1997). The development of PTSD, despite criticism, resulted in a vast body of literature related to psychological trauma (Weathers & Keane, 2007; Wilson, 1994) along with the validation of survivor experiences (Wilson, 1994). However, there is also recognition that traditional PTSD diagnoses may be unable to account for the full range of symptoms experienced by trauma survivors (Jones & Cureton, 2014). For example, van der Kolk et al. (2005) noted research demonstrates survivors of child abuse and interpersonal violence

report a variety of symptoms not included in a PTSD diagnosis. And many of the challenges to the definition and measurement of trauma remain unresolved (Weathers & Keane, 2007). The social and political context of trauma and many unanswered questions are indicative of an area still in need of significant exploration and development (Fassin & Rechtman, 2009; Herman, 1997). While we have made progress, the incomplete state of our current understanding reflects a research focus largely limited to understanding PTSD. Micale (2016) argued that our understanding of trauma is still in the early stages as our attention to it is a development of recent history and of limited breadth. He called for a much broader research agenda. The next section examines what is known relative to the consequences of traumatic events for survivors.

Trauma Survivors: The Impact of Life Changing Events

The focus of this study involved the potential benefits of a specific practice – tattoo acquisition. Therefore, it centered on therapeutic practices assisting recovery. However, it is necessary to first understand the nature of trauma and how it manifests in survivors. Researchers suggested due to the pervasiveness of trauma, "…most clients in the mental health system are trauma survivors" (Mejía, 2005, p. 31). Living through traumatic events results in clear, negative impacts to the mental health of survivors (Ghafoori, Barragan, & Palinkas, 2013). Understanding this impact requires a grasp of several factors. In this section, I first discuss trauma types, followed by individual considerations, and a brief note regarding diagnostic criteria. This discussion concludes with a review of characteristics commonly experienced by most people subjected to such experiences. Finally, I explore the more recent perspective of post-traumatic growth.

Trauma Types

Trauma occurs in all shapes and sizes. Traumatic experiences were first described in the DSM-III as events "…outside the range of usual human experience" (APA, 1980, p. 236). While once considered to be rare, traumatic events are now understood to occur frequently (Courtois & Gold, 2009; Herman, 1997). Trauma type is one way to categorize events based on their related characteristics (Ditlevsen & Elklit, 2012). Common examples include military or war experience, natural disasters, human-made disasters, criminal activity from burglaries to homicide, imprisonment, domestic violence, sexual assault, physical assault, car accidents, and personal illness (Herman, 1997; Putts, 2014). These events further fall into one of two general categories: 'Acts of God', denoting events that fall outside human control, or those that are human-induced (Courtois & Gold, 2009; Ditlevsen & Elklit, 2012). Trauma may also be considered within two other broad types: unrelated or related to psychosis, as psychosis itself may be traumatic (Putts, 2014). People may also experience trauma directly, or indirectly, through exposure to the traumatic experience of someone else (Courtois & Gold, 2009). Researchers emphasize the importance of differentiating between trauma-causing events. For example, studies suggest women survivors of interpersonal violence display characteristics not always indicated by the diagnostic criteria for PTSD. This is also true of survivors of childhood trauma (van der Kolk et al., 2005). It is clear researchers are just beginning to scratch the surface relative to the full range of trauma experience and expression. Two other common types of trauma include complex and historical.

Complex Trauma. Trauma presents itself in a variety of ways and is experienced along a continuum of severity influenced by the length of exposure and number of occurrences (Mejía, 2005). While trauma is complicated, it is made more complex if repeated or layered, which is

common in instances of combat or human trafficking, for example (Courtois & Gold, 2009; Herman, 1997). Such experiences are discussed in the literature as complex traumatic stress, complex post-traumatic stress disorder, and complex trauma. Trauma experiences in this category are sometimes referred to as Type II and are distinguished by prolonged, repeated, and chronic exposure to trauma causing events (Courtois & Ford, 2014; Herman, 1997; Warshaw, 2010). A common feature of Type II trauma is exposure to multiple trauma causing events (Warshaw, 2010) and the presence of social marginalization that in many cases further compounds the destructive impact (Briere & Spinazzola, 2014). Kallivayalil, Levitan, Brown, and Harvey (2013) noted the complexity of trauma and the difficulty of treatment for those who have experienced repeated exposure. In such cases, social disruption is a concern as relational issues are common (Herman, 2014) and may result in relationship issues and vulnerability relative to re-victimization.

Complex trauma and its impact has empirical backing. In one study, researchers reviewed the DSM-IV Field Test (van der Kolk et al., 2005). This foundational study included 400 participants seeking treatment related to trauma and another 128 community residents. The researchers developed a list of 27 trauma symptoms not included in the DSM-IIIR PTSD criteria. Results indicated that complex trauma results in symptomatology not fully captured by a PTSD diagnosis. They suggested trauma results in problems with inability to regulate affect, self-perception changes, somatization, interpersonal relationships, and dissociation (van der Kolk et al., 2005). The findings of the field test also suggested trauma exposure at an earlier age may be more disruptive than that occurring at later ages, that the symptoms are experienced along with others included in a formal PTSD diagnosis, and that length of exposure is a factor in symptomology. The implication is "…traumatized individuals develop a range of shifting

maladaptive patterns, depending on their stage of development, social support, and relationship to the origin of the trauma" (p. 396). van der Kolk and colleagues (2005) called for more research focusing on overall psychological impact beyond the PTSD diagnosis.

Historical Trauma. As the concept of trauma continues to develop, our knowledge regarding its reach grows (Fassin & Rechtman, 2009). The recognition of historical trauma is a more recent development and refers to collective trauma experienced over time. Initially, it emerged to help explain the experience of individuals in American Indian, Alaska Native, and other Indigenous populations (Kirmayer, Gone, & Moses, 2014; Prussing, 2014). Distinguishing features include: 1) a trauma-causing event, 2) shared by a group of people, that 3) spans a long period (Mohatt, Thompson, Thai, & Tebes, 2014). This last point is significant as it indicates the potential for individuals to be impacted by trauma without being present during the initial trauma-causing event (Mohatt et al., 2014). Researchers believe, "…there are universal processes of psychological adaptation that give rise to predictable forms of psychopathology for victims and their descendants" (Kirmayer et al., 2014. P. 303). Often occurring in socially marginalized groups, trauma reactions may be further heightened through present day discrimination (Prussing, 2014). This suggests such trauma continues as a narrative representation and may impact the current health of both individuals and communities (Mohatt et al., 2014). While researchers debate the concept of historical trauma, it received significant attention in the literature (Prussing, 2014). It also represents another point of polarization in our understanding of trauma while illustrating the growing complexity of trauma survivor experience and the need for culturally relevant mental health practice. The social and cultural context of the survivor will likely inform aspects of their experience and recovery (Kirmayer et al., 2014).

Our current understanding of trauma is highly influenced by socio-political factors over time. The literature on trauma types illustrates the breadth and reach of trauma events while speaking to the individuality of the experiences and their ultimate impact. I provide an overview of these personal variables next.

Individual Uniqueness and Response

The fourth revision of the DSM (DSM-IV-TR; APA, 2000) expanded the discussion of trauma to include individual responses. This acknowledgment pointed to the role of perception and helped explain the wide range of client reactions (seemingly little negative impact, to significant functional impairment) to traumatic events (Webber et al., 2006). Trauma includes both objective and subjective components, but it is the subjective experience that determines how a person views the event. Briere and Scott (2015) identified several factors that are present before a traumatic event that have a subsequent impact on reactions. They termed these factors "victim variables" (p. 26) and included gender, race, socioeconomic standing, age, coping ability, the presence of other psychological issues, family dysfunction, prior trauma, and genetic predisposition (Briere & Scott, 2015). The individual combination of these factors help determine how one experiences and ultimately copes with traumatic events.

An individual's response may also be influenced by the presence of hope and resiliency (Mejía, 2005). For example, evidence exists that people who believe they have control over their destiny tend to be more stress-resistant (Herman, 1997). Irrespective of personal variables, characteristics of the stressor or event itself influences individual response as well. For example, personal violations such as rape are more likely to produce PTSD symptoms than natural disasters (Briere & Scott, 2015). Lack of response or victim blaming also may result in further traumatization (Courtois & Ford, 2014). Also, a human-induced trauma that features betrayal and

interpersonal violence appears to result in more difficult coping (Herman, 1997). Greater damage may result if the act was willful (Courtois & Gold, 2009). Because of personal subjectivity and situation specific variables, the boundaries of individual trauma experience may appear elusive (Weathers & Keane, 2007).

Gender Differences

Gender politics are an inherent aspect of our society and present implications for trauma survivors as well. For example, Mejía (2005) suggested that typical male socialization results in men with diminished capability for trauma coping, complicating recovery and necessitating the exploration of salient aspects of masculinity and role expectations relative to trauma coping. At the same time, women historically have been socialized in ways that may lead to vulnerability relative to trauma (Blanch, Filson, Penney, & Cave, 2012). While some researchers explored gender differences in relationship to PTSD, limited research exists regarding the role of gender in other trauma reactions. The results of the available research are mixed, leaving questions about this interaction (Ghafoori et al., 2013).

Pulcino et al. (2003) investigated the prevalence of PTSD, from a public health perspective, in women following terrorist attacks in New York City on September 11, 2001. They cited a history of evidence that suggests women are at increased risk for the development of PTSD because of trauma experiences. Participants included 988 randomly selected individuals who lived in Manhattan. Data collection consisted of a telephone survey conducted 5-8 weeks following the attacks. Information gathered included trauma history, life stressors, social support, and other exposure variables. Results indicated that women in the sample were twice as likely to report PTSD symptomatology than men. They also suggested that individual factors, such as

additional ancillary stressors or other trauma exposure played a role (Pulcino et al., 2003). More work is needed to help understand the interaction of these variables.

Ghafoori et al. (2013), counseling and social work researchers, investigated gender in an urban sample of trauma survivors. Participants completed several assessment instruments and the researchers used chi-square tests to compare categorical variables and *F* tests to assess gender associations. Findings suggested significantly more exposure to sexual assault and domestic violence for the female participants. Regarding gender and the development of post traumatic reactions, women had an increased likelihood of developing PTSD and depression (Ghafoori et al., 2013). One limitation of this study was a higher probability of general mental health issues among participants to begin with given the selection criteria. The results of this research did support the idea that gender role expectations and gender differences in cognitive mediation may impact post-traumatic reactions.

Gender may also be considered in relationship to trauma type. Danish trauma researchers Ditlevsen and Elklit (2012) investigated the interaction of trauma type and gender in cases of PTSD. The study included a variety of trauma scenarios including natural disasters, disease, accidents, violence, and loss. Data was collected from 5,220 participants by an analysis of 18 convenience sample studies utilizing the *Harvard Trauma Questionnaire*. The results suggested women had twice the prevalence of PTSD as compared to men and were more vulnerable to symptoms following events such as disasters and accidents. Lesser differences existed in instances of violence and disease (Ditlevsen & Elklit, 2012). Overall, these findings supported earlier research indicating that gender is a consideration relative to trauma type and resulting trauma symptomatology.

Gender is a social construction (Mejía, 2005) and becomes another confounding variable to consider in terms of trauma survivor response and barriers to treatment. Briere and Scott (2015) discussed the role of gender and argued that women, for example, may not actually be more intrinsically vulnerable to trauma. Research suggested that women may be exposed to higher instances of trauma causing events, thereby accounting for the higher prevalence rates of PTSD symptomatology seen in studies. Yet, gender seems to have some bearing on the trauma experience of survivors (Ditlevsen & Elklit, 2012). More research is needed to understand the role gender plays in both our general response to trauma, and variance across the variety of trauma types.

Diagnostic Criteria Considerations

Due to the complexity of trauma, clients may meet the criteria for a variety of other diagnoses beyond PTSD (Mejía, 2005). ASD, first introduced in the DSM-IV (APA, 2004), focuses on brief periods of stress following an event. Also, a range of diagnoses may be comorbid with PTSD, such as dissociation, depression, bipolar disorder, anxiety disorders, substance abuse, psychosis, personality disorders, and physical illnesses (Courtois & Gold, 2009). Reactions to trauma may present themselves in varied ways.

As described, a host of personal, social, political, and cultural factors influences the psychological impact of trauma. It is important to recognize that the range of trauma experience may fall outside specific diagnostic criteria. For example, existential considerations often come into play and serve as a reminder not to rely on diagnostic criteria alone (Briere & Scott, 2015). Another issue involves seeking treatment. Survivors often first go to their primary care doctors who are generally untrained regarding psychological trauma and thereby lead to misdiagnoses and a delay in effective treatment (Courtois & Gold, 2009). Finally, due to the way trauma type

may be narrowly or broadly conceptualized, research studies may be negatively impacted regarding comparability (Ditlevsen & Elklit, 2012). While several factors come to bear in determining individual trauma response, research does provide evidence for a variety of issues common to survivors. These are discussed next.

Common Responses to Psychological Trauma

Even though people react differently to trauma, several common patterns exist. These include bio-psycho-social responses to direct and vicarious exposure (Webber et al., 2006). For example, research elucidated several common issues for complex trauma survivors including problems with emotional regulation, changes in consciousness such as repressed memories or dissociation, unexplained physical pain and other somatic symptoms, general sense of alienation from others, identity confusion, lack of boundary awareness, and disrupted relationships (Briere & Scott, 2015; Herman, 1997, 2014). Grief is a normal reaction to loss as well and may become exacerbated or more complicated depending on the severity and nature of the traumatic event (Briere & Scott, 2015). This broad response reflects the complexity of trauma, which often manifests in issues inclusive of power, trust, helplessness, pain, and feelings of betrayal (Dutton, 2000; Gobin, 2012). Traumatic experiences result in a sense of powerlessness and are disruptive to our normal ability to make sense of events (Herman, 1997). "Those who are traumatized will develop characteristic responses that may include intrusive recollections of the event; avoidance of the traumatic situation, with a numbing of general responsiveness; and increased physiological arousal" (Mejía, 2005, p. 30). These and other typical responses form the sequelae of trauma aftermath experience. Briere and Scott (2015) outlined several broad, common responses including stress disorders, depression, anxiety, disassociation and psychosis, and substance abuse.

Stress Disorders

The research on PTSD suggests that prevalence in survivors with direct exposure to trauma is in the 30-40% range (Galea, Nandi, & Vlahov, 2005). Those with greater exposure to trauma seem to have a greater stress response (Ying, Wu, Lin, & Jiang, 2014). One obstacle to a better understanding of this process is the aforementioned context of PTSD development and changing criteria over time (Galea et al., 2005). Changes to the most current revision of the DSM make ASD more applicable to trauma survivors (Briere & Scott, 2015), further underscoring the need to understand the stress response. The following research offers the varied results related to stress disorders after traumatic experiences.

PTSD and ASD capture the overwhelming symptomatology experienced by survivors (Briere & Scott, 2015). Physiological responses or hyper-arousal may manifest as sleep disturbances, hypervigilance, irritability, and issues with concentration, outbursts, and exaggerated startle response (APA, 2000; Flannery, 1999). A variety of intrusive thoughts may occur in survivors including reimagining the event through images, thoughts, flashbacks, daydreams, and nightmares (Matsakis, 1994). The resulting quality of these thoughts is the general feeling that the person is reliving the experience (van der Kolk, McFarland, & Wisaeth, 1996), along with general disruption to normal human development (Herman, 1997). There is a pervasive sense of always needing to be at the ready for what may happen (Flannery, 1999; Herman, 1997; van der Kolk et al., 1996).

Psychiatric and trauma researchers Mueser, Lu, Rosenburg, and Wolfe (2010) studied clients experiencing a first psychotic episode. They recognized that psychosis may lead to the development of PTSD. Participants included 38 individuals who presented with a psychotic episode at two state psychiatric hospitals. Measures included assessment of lifetime exposure to

trauma, PTSD symptoms, psychiatric symptoms, substance abuse, and coping strategies. More than 50% of the participants reported significant distress regarding the experience of psychosis and 39% met the criteria for PTSD. Sixty-six percent had symptoms related to PTSD syndrome (Mueser et al., 2010). They concluded that the DSM criteria for traumatic events does not capture the experience of all survivor groups.

Psychology and health researchers Au, Dickstein, Comer, Salters-Pedneault, and Litz (2013) investigated the co-occurrence of PTSD and depression in survivors of sexual assault. Their aim was to determine patterns and distinctions in this relationship. Participants included 119 female sexual assault survivors. Self-report measures explored PTSD and depression symptoms at various intervals following the assault. Latent profile analysis revealed that PTSD and high depression severity co-occurred among this population. They found no distinctions between the two conditions suggesting that both may be part of a broader post traumatic response (Au et al., 2013). Based on these findings, the researchers suggested interactive approaches that target both sets of symptoms may be more beneficial.

In a related study, mental health researchers Atwoli et al. (2013) focused their study within the context of historical and political trauma. The purpose of their work was to evaluate trauma and PTSD present in the general population of South Africa. Of the 4,315 respondents, over 70% had been exposed to a potentially traumatic event, in addition to having a 2.3% lifetime prevalence rate of PTSD. This rate of PTSD was lower than in studies from other countries. Its onset appeared to be highest in cases where participants witnessed trauma to others. This type of trauma accounted for 50% of the PTSD cases in the study (Atwoli et al., 2013). These results supported previous findings related to the impact of interpersonal trauma.

In a study of women veterans supported by the Department of Veteran Affairs, behavioral science and substance abuse researchers Lehavot and Simpson (2014) examined the relationship between PTSD, depression, and trauma. They also sought to explore differences between sexual orientation within this population. An anonymous online survey included 706 women, of which 37% identified as lesbian or bisexual. A variety of assessments were included to gather data on childhood trauma, adult sexual assault, combat exposure, experience with sexual discrimination, military stressors, and mental health history. Lesbian and bisexual participants reported higher instances of trauma. Of these participants, 39% of the lesbian and bisexual women and 32% of the heterosexual women screened positive for PTSD (Lehavot & Simpson, 2014). Interpersonal trauma appeared to be highly predictive of PTSD and depression symptoms, congruent with other findings. The researchers called for more research investigating trauma type and personal variables.

Goldstein, Dinh, Donalson, Hebenstreit, and Maguen (2017) also studied PTSD and depression in female veterans. Their aim was to build on previous work related to combat trauma calling for a focus on unique variables. Participants from a Veterans Health Administration medical center completed assessments about military background and mental health. Multiple regression analyses revealed a history of sexual assault to be a strong predictor of PTSD and depressive symptoms (Goldstein et al., 2017). Like other studies, interpersonal trauma or the witnessing of trauma were also predictive of PTSD. They called for continued mindfulness regarding individual factors and needs of survivors.

Although PTSD has received criticism, one advantage is the facilitation of finding commonality among a wide variety of trauma types and symptoms. Stress reactions clearly

present as significant in the trauma response. Yet, more information is needed regarding interaction of variables and other underlying mechanisms.

Depression

Several research studies indicate trauma survivors are at an increased risk for developing a range of depressive disorders (Briere & Scott, 2015). Depression is also highly comorbid with, and possibly an outcome of, the stress related disorders (Au et al., 2013; Fowler, Allen, Oldham, & Frueh, 2013). This connection is likely a reason many studies address both conditions during investigations. Due to its prevalence following trauma, Briere and Scott (2015) urged that it should always be considered.

Psychiatrists Nanni, Uher, and Danese (2012) investigated depression resulting from childhood maltreatment experiences. They observed that early trauma experiences place an individual at a lifetime increased risk of developing depression. This study was the first meta-analysis examining the association of maltreatment and measures of depression. The researchers used academic databases to search for relevant data and selected 16 epidemiological studies that consisted of 23,544 participants. Results of the meta-analysis suggested that individuals who experienced childhood maltreatment were twice as likely to experience recurring and persistent depression (Nanni et al., 2012). These results supported previous findings relative to childhood maltreatment and suggest the need for early intervention.

In a study by researchers associated with The Menninger Clinic, a leading psychiatric hospital, Fowler et al. (2013) examined the role of interpersonal trauma in the development of depression. Given its prevalence in prior research, they considered attachment as a mediating factor. Participants included 705 admitted adults. Past trauma, attachment anxiety, depression, and avoidance were measured. Results indicated that interpersonal trauma such as abuse

positively correlated with the development of depression. However, this was not the case with other non-personal trauma types such as natural disasters. These results suggested that attachment insecurity played a role in depression following trauma. They concluded that more knowledge is needed about linkages between trauma experiences and the development of depression (Fowler et al., 2013).

Psychiatry and social work researchers Dekel, Soloman, Horesh, and Ein-Dor (2014) investigated the relationship of depression and PTSD in trauma within the context of captivity and combat trauma. In this longitudinal study, they investigated symptomatology three separate times over a 17-year period. Participants included 275 former prisoners of war and 219 combat veterans from the same war that comprised a control group. Results indicated that PTSD and depression were higher in the ex-POWs. Depression was higher than PTSD in both groups at each of the assessment points. They suggested that depression is a long-term consequence of trauma events, and along with PTSD, may be part of a unified post-trauma response (Dekel et al., 2014).

There are several detrimental consequences of childhood sexual abuse. One recent study by university researchers examined adolescent survivors of this abuse type for response characteristics (Mclean, Morris, Conklin, Jayawickreme, & Foa, 2014). Participants included 83 adolescent females in treatment for PTSD. Measures assessed for affective disorders, PTSD, trauma history, depression, and suicidal ideation. Of these women, 40.5% had experienced a single episode of child sexual abuse and another 23.8% experienced multiple or ongoing episodes. While depression for the sample fell within a clinical range, no relationship was found related to characteristics of the trauma experienced (Mclean et al., 2014). This was an unexpected result that may be explained by individual characteristics and factors.

University affiliated nursing researchers Kukihara, Yamawaki, Uchiyama, Arai, and Horikawa (2014) noted a previous, strong relationship between natural disasters and the development of PTSD in survivors. In their study, the aim was to investigate the prevalence of such conditions, along with resiliency factors, in survivors following a combined natural/nuclear disaster in Fukushima, Japan. Participants included 241 evacuees from the area. Results indicated that 66.8% of this group experienced symptoms of depression. Resilience was found to be helpful in managing both depression and PTSD. They concluded that natural disasters and nuclear incidents lead to the development of depression and PTSD in survivors. They also noted that helpers should focus attention on building resiliency as a coping mechanism (Kukihara et al., 2014).

In research funded by the National Institute of Mental Health, healthcare system researchers Bedard-Gilligan et al. (2015) investigated depression and trauma history as influencers of PTSD severity. Depression and PTSD symptoms often occur together, and various relationship qualities exist between the two, but more understanding is needed regarding their interaction. Participants included 200 men and women included in a PTSD clinical trial. Measures assessed trauma history, depression history, dissociation, and comorbidity. In this sample, co-occurring depression was "…associated with more severe symptoms, poorer functioning, more dissociation, greater past treatment attempts, and more current co-occurring diagnoses" (p. 735). Past experiences of high level trauma were also associated with greater depression, which in turn was predictive of diminished overall functioning. Like other recent findings, they concluded that comorbidity of PTSD and depression may be indicative of increased severity of trauma impact, and suggestive of a broader trauma response than captured in current PTSD diagnostic criteria (Bedard-Gilligan et al., 2015).

Depression is often included in studies alongside PTSD. While the research demonstrates a clear link between trauma exposure and depression, less clear is the underlying mechanism and association with PTSD and other trauma symptoms beyond high comorbidity. Like PTSD, however, the likelihood of its development following trauma exists, and greater exposure appears to manifest in increased severity of symptoms.

Anxiety

Responses to trauma exposure often involve heightened vulnerability which in turn precipitates the onset of generalized anxiety, panic attacks, and phobias (Briere & Scott, 2015). Avoidance is a known consequence of trauma and may be experienced as a need to avoid places or thoughts connected to the traumatic event, difficulty with recollections, loss of interest in important aspects of life, and restricted emotions (Mejía, 2005). Symptoms of anxiety also tend to be highly comorbid with PTSD and depression in survivors (Courtois & Ford, 2014).

United Kingdom psychiatric researchers Mayou, Ehlers, and Hobbs (2000) investigated the role of psychological debriefing used with traffic accident survivors. The aim of this research was to evaluate the outcome of debriefing three years following intervention. Participants included 61 individuals who were originally part of a randomized control trial of hospital admissions following a traffic accident. Findings revealed poor outcomes, with participants still experiencing a variety of issues. This included travel anxiety along with high intrusion and avoidance symptoms (Mayou et al., 2000). While the focus of this research was on the effectiveness of debriefing, anxiety became a noted consequence of participant experiences.

University affiliated psychology researchers Grant, Beck, Marques, Paylo, and Clapp (2008) also observed that anxiety is highly comorbid with depression. In their research, they examined the structure of distress in trauma survivors to distinguish between depression, anxiety,

and PTSD. Participants included 228 survivors of traffic accidents. Self-reported measures and interviews were used to assess for PTSD, depression, and anxiety. Results indicated that distinctions could be made between these different constructs, however, they commonly occurred together. Generalized anxiety in the survivors presented unique symptoms including restlessness, fatigue, muscle tension, concentration difficulties, and irritability. Grant et al. (2008) suggested more research is needed with different trauma types.

In another study of trauma and anxiety, psychology researchers Cougle, Timpano, Sachs-Ericsson, Keough, and Riccardi (2010) examined anxiety disorders in survivors of childhood physical and sexual abuse. These researchers identified issues with previous studies in this area, especially in terms of distinguishing between trauma type. Participants included a representative sample of 4,141 individuals utilizing data obtained from the National Comorbidity Survey-Replication. Structured interviews explored abuse history, mental health history, anxiety, and demographics. Multivariate logistic regression analyses of the data indicated an association between sexual abuse history and the development of social anxiety disorder, panic disorder, and generalized anxiety disorder. Physical abuse was associated with specific phobias. Cougle et al. (2010) also found gender differences, with more anxiety disorders reported by female participants. These results point to potentially important gender distinctions, but more research is needed to understand the associations.

Like depression, anxiety appears to link with PTSD. Cougle, Feldner, Keough, Hawkins, and Fitch (2010) studied the comorbidity of these constructs within the context of trauma event exposure history. Specifically, they examined instances of comorbid panic attacks in 203 individuals. Inclusion criteria sought those meeting the DSM criteria for PTSD during the previous year. Findings revealed that 35% of the sample experienced panic attacks. Panic attacks

were also associated with a greater likelihood of depression, substance abuse, somatic complaints, anxiety, and stress. The researchers concluded that panic attacks were common in trauma survivors who experience PTSD (Cougle et al., 2010).

Anxiety is apparent in trauma survivors and often appears alongside stress disorders and depression. Likewise, anxiety is another response that requires more understanding relative to the underlying processes involved. It does appear to be related to several potential reactions that diminish survivor functioning.

Disassociation and Psychosis

As noted previously, early theories connected dissociation experiences with trauma exposure (Gentry & Baranowsky, 2002). DePrince and Freyd (1999) defined the condition as, "the lack of integration of thoughts, feelings, and experiences into the stream of consciousness" (p. 449). Researchers and practitioners often observe dissociation in survivors (Stein et al., 2013). This is true of psychotic episodes as well (Mueser et al., 2010; Perona-Garcelán et al., 2010). A psychotic disorder may be the chief concern and presents in the form of hallucinations, disorganized thinking, and confusion along with a history of trauma (APA, 2000; Putt, 2014). Research suggests that up 73% of childhood trauma survivors experience psychotic symptoms (Bendall, Jackson, Hulbert, & McGorry, 2008). There also appears to be a relationship between increased trauma exposure and multiple psychotic episodes (Putt, 2014).

Interdisciplinary researchers Perona-Garcelán et al. (2010) investigated the relationship of traumatic experiences with dissociation and psychosis. They noted previous research correlated dissociation with earlier physical and emotional abuse. Participants for this study were 37 adult patients diagnosed with psychoses in a Spanish mental health unit. Of these participants, 40.5% experienced trauma as a child, and 64.9% as an adult. Results indicated that of those

experiencing hallucinations, a higher number experienced childhood trauma than those without. Those who suffered childhood trauma also scored higher on the dissociation scale (Perona-Garcelán et al., 2010). These findings supported rates found in previous research.

Kelleher et al. (2013) explored the relationship of psychosis with a history of childhood trauma. They explained that this link was noted in previous research but the underlying mechanism remains unresolved. Data collection consisted of information from 1,112 adolescents recruited from a nationally represented cohort study. The assessments were administered at the beginning of the study and during follow-ups conducted at the three- and 12-month marks. Results indicated a bidirectional relationship between trauma and psychosis. In other words, evidence suggested that trauma precipitated psychosis and vice versa. However, even after controlling for other variables, early trauma remained a strong predictor of eventual onset of psychotic experiences in this population. Further, they found reduction in trauma to be associated with a reduction in psychosis (Kelleher et al., 2013). This last finding suggested a direct connection between the two constructs.

Stein et al. (2013) investigated the prevalence of dissociation in PTSD cases. Although not focused on trauma experiences, the aim of this research was to add to the evidence under consideration for the inclusion of a dissociative subtype of PTSD in the DSM-5 revision. The researchers interviewed 25,018 participants from 16 countries. Measures included the *Composite International Diagnostic Interview* in addition to checklists of psychological distress history, exposure to trauma, and PTSD. Results indicated that 14.4% of the respondents displayed dissociative symptoms. This rate was consistent across various demographic and socioeconomic differences. They also found several confounding variables and individual factors that seemed to contribute to the development of dissociation (Stein et al., 2013). They concluded that these

findings support the relevance of establishing a dissociative subtype to help explain severe PTSD cases.

Psychology researchers Gómez, Kaehler, and Freyd (2014) examined hallucinations and dissociation in cases of betrayal trauma. This type of trauma involves a betrayal of trust (i.e., child sexual abuse by a caregiver) and links to several negative outcomes. This research consisted of three exploratory studies, each with 199 to 566 undergraduate psychology students, focused on betrayal, abuse, dissociation, and hallucinations. Findings demonstrated increased instances of both dissociation and hallucination in cases of exposure to betrayal trauma. The researchers asserted the need for increased understanding of relational factors in the treatment of survivors (Gómez et al., 2014).

Disruption in the form of distorted thinking and other cognitive anomalies often appear to manifest in trauma survivors, especially if that trauma is of the betrayal variety. Less clear are reasons for individual differences in its development. More work is needed to understand the relationships involved.

Substance Abuse

Substance abuse is another common result in trauma survivors, especially in cases of interpersonal trauma. For example, there is a clear link in women with a sexual assault history (Ullman, Relyea, Peter-Hagene, & Vasquez, 2013). Substance use following trauma may signal avoidance or a coping attempt to self-medicate and reduce the pain of those experiences and their consequences (Ullman et al., 2013). Others suggested that the use of substances may serve as a precursor by placing a person at greater risk for trauma exposure, and/or that substances may act as an enhancer of symptom severity (Briere & Scott, 2015). Therefore, the underlying pathway and direction of this association remains unclear.

In a study of childhood trauma exposure, National Institute on Alcohol Abuse and Alcoholism researchers (Huang, Schwandt, Ramchandani, George, & Heilig, 2012) investigated mental health comorbidity among a population of substance abuse inpatients. They cited prior work that established a link between substance use and trauma experiences and specifically wanted to differentiate between various types of childhood trauma. Participants included 196 inpatients at the National Institute on Alcohol Abuse and Alcoholism Inpatient Unit. Measures included assessment of mental health issues and childhood history exposure. Of this sample, 55.1% reported a history of childhood trauma including various forms of abuse and neglect. Of those, just over 50% reported exposure to more than one type of trauma. They also found that a trauma history increased the likelihood of experiencing a variety of mental health issues (Huang et al., 2012). These numbers suggested a relationship between childhood trauma and substance abuse.

Ullman et al. (2013) examined the association of substance abuse in those with a history of sexual assault. Their study focused on women and how problematic substance abuse manifested in those with trauma histories. Participants included 1,863 adult women sexual assault survivors. Measures assessed sexual victimization, child sexual abuse, trauma history, PTSD symptoms, and substance use behaviors. Results suggested that a more severe trauma history was associated with greater substance use. It also appeared that interpersonal trauma types specifically predicted the use of substances as a coping mechanism (Ullman et al., 2013). They concluded that trauma history type should be assessed to determine the likelihood of and mechanism of substance use issues, yet research in this area is limited.

In another study of childhood trauma, Grabbe and Zhang (2014) investigated the role of substance abuse in survivors. Participants included eight trauma survivors being treated for

addiction, who ranged in age from 27-46. In this qualitative study, semi-structured interviews helped build narratives regarding trauma history and substance use. All participants experienced betrayal trauma, characterized by lack of nurturance, and multiple episodes of abuse. Relative to substance use, a major theme involved early and regular use of drugs and alcohol as a means for coping. This behavior seemed to provide temporary relief but ultimately resulted in further disruption (Grabbe & Zhang, 2014). The experiences of participants in this study suggested a clear link between trauma and later substance use issues.

Neuroscience and prevention researchers Ehlers et al. (2016) examined the association of trauma history with substance abuse, depression, stress, and PTSD in Mexican Americans. Participants included 614 people contacted through a commercial mailing list. A phone interview was used for initial screening and selected participants completed interviews to assess mental health and stress levels. Results revealed 45% of the sample had experienced at least one traumatic event. Alcohol dependence was highly associated with those experiencing PTSD. This was not the case for other drugs such as nicotine, marijuana, or stimulants. Ehlers et al. (2016) also found that alcohol dependence developed following a diagnosis of PTSD, suggesting it may be a risk factor for further issues. They surmised there may be differences between cultural groups relative to substance use that warrant further investigation.

Less research is available that exclusively examines substance abuse in trauma survivors and when discussed, it is often addressed as a secondary issue. Anecdotally, Rosenberg (2011) suggested that most clients seen for substance abuse issues have a history of trauma, and the greater the trauma the more those individuals are at risk. Therefore, it is important to consider the role substance use plays for trauma survivors. Research demonstrates that focusing on one area alone may exacerbate symptoms in another. An integrative approach has produced promising

results in addressing substance use in concert with other areas while reducing the likelihood of relapse (Dass-Brailsford & Myrick, 2010).

While research of trauma exposure response is not always clear, it does point to areas of commonality in expression across multiple trauma types and scenarios that occur around the globe. There is a profound impact to survivors of emotional trauma. Trauma often presents in a variety of ways especially related to stress, depression, and anxiety. Other common developments include cognitive issues and substance abuse. In summary, the experience is often one of constriction, or a state of psychological surrender. The survivor may alter consciousness in a variety of ways including distorted perceptions, detachment, dissociation, retreating from normal life and connections, and other alterations (Herman, 1997). In short, this constellation of potential responses may contribute to a summative experience of powerlessness, hopelessness, and distrust. Although this section describes the negative outcomes for trauma survivors, evidence does exist for enhanced opportunities for growth as well.

Trauma Survivors: Restoration and Growth

The primary goal of treatment is the restoration of functioning and the development or strengthening of coping skills. As alluded to above, this is a complex and varied process (Mejía, 2005). Searching for client strengths and resilience may help combat the impact of trauma. The notion of growth in the face of significant challenge is present throughout myth, literature, and religion (Calhoun, Cann, & Tedeschi, 2010). There is also growing recognition in research that trauma experiences may be salutogenic or psychologically beneficial, thereby transforming and increasing resilience along with meaning making in survivors (Calhoun & Tedeschi, 2014; Dekel, Ein-Dor, & Soloman, 2012; Tedeschi & Calhoun, 1995). The perspective of post-traumatic growth is an important one as it helps provide for a comprehensive understanding of

trauma (Courtois & Gold, 2009) and scope of what effective adaptations to trauma look like (Boxer & Sloan-Power, 2013). Before discussing post-traumatic growth however, a distinction needs to be made between two other related and sometimes overlapping constructs, coping and resilience.

Coping strategies are the means for adjustment to and protection against the impact of trauma (Altmaier, 2011). Coping styles vary greatly by individual and help determine the extent of growth possible following an event. For example, coping styles may be positively related (i.e., focus on emotions) or negatively related (i.e., denial) to growth following trauma (Linley & Joseph, 2004; Ramos & Leal, 2013). Coping strategies are largely learned (Boxer & Sloan-Power, 2013). Finally, coping generally refers to concrete examples or specific behavioral strategies for alleviating symptoms. Therefore, coping is important when considering the possibility and scope of post-traumatic growth but does not necessarily represent growth itself. Warshaw (2010) noted that resilience is the ability to adapt to difficult experiences despite their significance. It is a positive adaptation in the face of aversive events (Bonanno, 2004; Herrman, Stewart, Diaz-Granados, Berger, Jackson, & Yuen, 2011; Ungar, 2013) and is characterized by recovery, resistance, and reconfiguration (Lepore & Revenson, 2006). These processes may be influenced by both developmental level and the major life area under consideration (Herrman et al., 2011). Therefore, resilience is not an all-encompassing characteristic and may become a factor based on individual circumstances. Like coping, resilience may be related to a positive adaption to extreme stress, yet the concept of post-traumatic growth is considered a separate construct (Herrman et al., 2011).

Post-Traumatic Growth

Post-traumatic growth may be distinguished from resiliency in that it focuses only on the positive outcomes and is itself an outcome of reconfiguration (Lepore & Revenson, 2006). It should be noted that there is unresolved debate about this distinction (Ramos & Leal, 2013). Nevertheless, some research supports the idea of growth from trauma. Positive outcomes reported by sexual assault survivors for instance include "…making changes in one's life philosophies and priorities, development of value for oneself and others, and an increased role of spirituality in life" (Stermac, Cabral, Clarke, & Toner, 2014, p. 302). These outcomes speak to the important process of meaning and growth following trauma causing events. Previous research makes a connection between optimism and hope and lowered feelings of distress. Evidence also exists for a positive association with better functioning personal relationships, improved coping, and a reduction in avoidance (Prati & Pietrantoni, 2009; Tedeschi & Calhoun, 2004) following trauma. These benefits directly oppose the common responses found in trauma survivors.

In an early study of this area, psychology researchers Davis, Nolen-Hoeksema, and Larson (1998) examined how people think about events in which they are involved. Participants were recruited from hospice settings and researchers interviewed them before and after the death of family members along with asking for completion of a variety of assessment measures. Two important considerations included meaning-making and whether participants found anything positive related to the event. Of the 205 respondents who completed pre- and post-loss interviews, results indicated those who found meaning, or some beneficial aspect of the experience, were better adjusted and reported they had learned something about themselves (Davis et al., 1998). This meaning-making led to improved adaptive coping.

The way we think about our experiences may mediate responses. Nolen-Hoeksema and Davis (2004) for example, suggested that reflective, oriented rumination about events results in lower levels of depression. Psychology researchers Taku, Cann, Tedeschi, and Calhoun (2009) investigated the role of such rumination in post-traumatic growth. Their study assessed rumination by using the *Rumination Scale* and the *Posttraumatic Growth Inventory* with 224 participants from the United States and another 431 from Japan. Four types of rumination styles were compared using Pearson correlations. Both intrusive and deliberate ruminations were positively associated with post-traumatic growth. There were differences found between the U.S. and Japanese samples, but in both cases, the deliberate rumination style was most strongly associated with growth, supporting the use of ongoing cognitive processing (Taku et al., 2009). These results suggest that rumination might lead to post-traumatic growth.

In a more recent study, a team of psychology, trauma and human development researchers (Wagner et al., 2016) investigated the role of treatment in the facilitation of post-traumatic growth. Forty couple/pair participants completed a controlled trial utilizing cognitive-behavior therapy. Results indicated that participants in the trial demonstrated a significant increase in post-traumatic growth versus those on a three-month waitlist (no treatment). This result was true even though post-traumatic growth was not a primary focus, indicating that the treatment process itself played a major role in its development (Wagner et al., 2016). These results suggest that therapeutic intervention played a role in growth following trauma.

Israeli psychology and social work researchers Dekel et al. (2012) considered other factors related to distress and growth. Israeli ex-prisoners, who were victims of captivity, were followed over the course of 17 years and markers of PTSD, depression, and anxiety were measured at three points: 1991 (n=164), 2003 (n=144), and 2008 (n=183). Results suggested that

the presence and endorsement of PTSD directly related to the facilitation of growth. Growth seemed to be a direct outcome of the emotional struggle that occurred after experiencing distress (Dekel et al., 2012). These findings support the view that survivors may become stronger because of their experiences.

Other studies are contradictory and found a lesser connection between distress and growth. Stermac et al. (2014) investigated factors that mediated mental health in sexual assault survivors from a counseling psychology perspective. Participants included seventy-three (93.1% female) individuals who reported a history of sexual violence. The researchers explored the relationship between factors under investigation with post-traumatic mental health. Results indicated a low incidence of post-traumatic growth for this population, as participants showed high levels of distress three years following their experience. Results also suggested that reflective rumination did not lead to growth. However, participants also reported low levels of social support in general which may have effected trauma coping (Stermac et al., 2014). This mixed finding underscores the need to assess broad, ecological factors.

This limited body of research supports the notion of growth following trauma. Joseph and Linley (2008) observed, "an enduring wonder of human nature is that many people respond to traumatic events by experiencing posttraumatic growth. They often become stronger personally and deepen their connections to other people as well as their faith life" (p. 105). Individual characteristics, emotional disclosure, satisfaction with social support, and a deliberate rumination style all seem to contribute to an adaptive re-evaluation of life (Cann, Calhoun, Tedeschi, Triplett, Vishnevsky, & Linstrom, 2011; Dekel et al., 2012; Linley & Joseph, 2004; Prati & Pietrantoni, 2009; Ramos & Leal, 2013; Taku et al., 2009). Like resilience, an individual's sociocultural context likely impacts the quality of growth following trauma in a variety of ways

(Calhoun et al., 2010). The concept of post-traumatic growth is a relatively new research focus. And despite the promise held, inconsistency of findings limits understanding due in part to methodological issues (Dekel et al., 2012) and mixed results. More evidence is needed regarding the underlying processes at work, the relationship between and coexistence of both negative and positive consequences of trauma, and subsequent outcomes related to trauma treatment.

Bearing Witness: Trauma Survivors and the Road to Recovery

While the effects of trauma have long received scrutiny, the comprehensive therapeutic treatment of the aftermath is an advent of more recent history. Although the impact of war received research attention, community based treatment approaches were not established until the 1940s. Crisis intervention received attention following the 1942 Coconut Grove nightclub fire that resulted in 493 deaths. While treating survivors, Lindemann (1944) recognized many shared, common emotional responses and the need for therapeutic intervention and support. His recognition of this grieving process, along with work stemming from collaboration with Gerald Caplan, resulted in the creation of the *Wellesley Project*, the first community mental health program (Caplan, 1961). The purpose of this project was to research and provide support for survivors of traumatic events.

A second development that informs trauma helping may be considered psychological first-aid. Research findings regarding the short-term impact of trauma on survivors and a recognition that coping tends to take place during the initial period following an event (Tuval-Mashiach et al., 2004) led to practices designed to address immediate needs (Vernberg et al., 2008). While specific protocols remain elusive due to a lack of validation, psychological first-aid became an important intervention as the mental health fields increased their role in disaster response (Reyes, 2006; Vernberg et al., 2008). Such practices are evidence-informed and must

meet four standards including, 1) congruent with evidence related to risk and resilience following trauma, 2) useful in field settings, 3) developmentally appropriate, and 4) culturally informed (Brymer et al., 2006). Psychological first-aid represents a practice that continues to adapt based on trauma scenarios while informing counselors about survivor needs (Vernberg et al., 2008).

Finally, a third practice supporting trauma was the emergence of trauma-informed care. Associated approaches encourage a commitment to recognizing and understanding the impact of trauma in society while also considering the ecological and cultural contexts in which it occurs (SAMHSA, 2014b). Cultural competence is critical as the experience of trauma is influenced by factors such as ethnicity, gender, and sexual orientation (Brown, 2008). Experts agreed that key elements include, 1) understanding the prevalence of trauma, 2) understanding the impact of trauma throughout the systems in which we work, and 3) putting this knowledge into practice (SAMHSA, 2012). Such care translates into service "…that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). In a meta-analysis of PTSD treatments, trauma-informed approaches were shown to be the most effective (Bisson et al., 2007). Malott and Schaefle (2015) also observed that trauma-informed practices are useful with clients who have experienced racism since the approaches are sensitive to systemic issues such as generational racism. In short, clinicians remain mindful of trauma impact with each client seen (Rosenberg, 2011). The advent of trauma-informed care is important as it positions the recognition of trauma at the forefront of services provided, acknowledging its deep and pervasive reach.

This brief history traced the development of responses to trauma that paved the way to current day efforts and interventions in clinical settings. These clinical approaches are discussed next and focuses on those most examined in the literature. Attention is paid to recovery interventions within the context of counseling.

The Use of Counseling to Address Trauma Survivor Suffering

Counseling is a primary vehicle through which survivors may begin moving forward and increased attention is being placed on its role with survivors (Kallivayalil et al., 2013). A variety of possibilities exist. Modern approaches may be traced back to the work of Freud and Janet with an emphasis on exposure and re-experiencing (Webber et al., 2006). Researchers recognize that Freud's thinking on trauma prevailed in the consciousness of mental health perspectives well into the 20th century and heavily influenced diagnostic criteria through the DSM-III, at which point the surge in trauma research began (Wilson, 1994).

Within this basic conceptualization, several orientations and techniques are available to counselors. Webber et al. (2006) stressed that expert guidelines are needed because research in this area tends to be difficult to generalize or fails to answer the breadth of questions that arise in clinical settings. While they noted the importance of research informed practice, they also asserted that the complex realities often faced by counselors in such situations call for acknowledgement of expert consensus. Foa, Davison, and Frances (1999) gathered expert consensus on a variety of trauma related treatment targets in clients suffering from PTSD. For example, they advised a combination of cognitive therapy and psychoeducation to address guilt and shame, or anxiety management and psychoeducation for anxiety. They also consolidated recommendations based on factors such as the most overall effective techniques, quickest acting, most acceptable, and safest (Foa et al., 1999). While such preferences and recommendations

continue to evolve with time, they inform counselors of best practices for a variety of survivor issues (Webber et al., 2006).

Herman's Three-Stage Model of Trauma Recovery

A widely used, effective, and reference standard guideline is the three-stage model developed by Herman (1997) that proposed recovery phases including safety and stabilization, remembrance, and reconnection (Appelbaum, 2008; Baranowsky & Gentry, 2002; Baranowsky, Gentry & Schultz, 2004; Webber et al., 2006). She was the first to develop a stage-based recovery model informed by research literature and clinical observations (Mendelsohn et al., 2011). *Safety* involves the process of recovery within a therapeutic relationship where a client strives for a sense of stability by regaining control over internal states and external events. This includes the need for a general sense of safety, regulation of emotions, and trust within the therapeutic alliance. During the *remembrance* phase, the counselor assists the survivor by bearing witness as work begins relative to reconstructing the traumatic event. This stage signals movement to a place where the client is ready to process internal emotions. Finally, *reconnection* involves meaning making and ultimately the redefinition of oneself. During this stage, the client is also able to become more present in areas such as work, relationships and leisure (Baranowsky & Gentry, 2002; Baranowsky, Gentry & Schultz, 2004; Herman, 1997; Mejía, 2005; Rappaport, 2010; Webber et al., 2006). The goal of this foci is replacement of disruptive processes along with closure, and recognition that trauma experiences do not determine identity (Meíja, 2005; Menselsohn et al., 2011; Webber et al., 2006).

These stages as articulated by Herman are accepted in the literature as the basic progression survivors must take on the road to recovery and reconnection. While standards continue to evolve regarding trauma treatment, research into specific approaches has provided us

with a variety of trauma-informed interventions, discussed next. Research is centered on the prevailing counseling approaches noted in Chapter One and is organized here relative to their association with Herman's stages.

Clinical Interventions: Establishing Safety

Herman suggested that the therapeutic alliance offers one of the first points to begin working on the rebuilding of safety and trust with survivors. It is also the foundation for reconnection that becomes important within the overall context of the model and is required as a prerequisite of trauma work (Lewis, 1996; Menselsohn et al., 2011; Tenenboim-Weinblatt, 2008). The relationship is one of collaboration and cooperation that in a sense directly contradicts the trauma experience (Herman, 1998). Work during this stage involves helping a client regain control over both body and environment (Lewis, 1996; Menselsohn et al., 2011). Limited empirical research is available directly related to establishing safety, with the strongest connection found in studies relative to trauma and the therapeutic alliance.

A team of psychology and violence researchers, Price, Hilsenroth, Callahan, Petretic-Jackson, and Bonge (2004), investigated the effectiveness of psychodynamic psychotherapy with survivors of childhood sexual abuse. A secondary purpose of the study was to compare the therapeutic alliance between those who had experienced trauma and those who had not. Participants included 33 individuals receiving assistance from a university-based community clinic. Assessments included the *Clinical Interview*, *Abuse Dimensions Inventory*, *Symptom Checklist-90-Revised*, *Social Adjustment Scale*, *Social Cognition and Object Relations Scale*, *DSM-IV Rating Scales*, *Patient's Estimate of Improvement*, and *Combined Alliance Short Form*. The mean length of treatment was 26 sessions over six months. Results suggested that the therapeutic alliance was an important factor of effectiveness in the trauma group during the

entire treatment span (Price et al., 2004). This relational quality appeared to result in both interpersonal functioning gains and client satisfaction.

One study examined evidence-based practices with PTSD by Veterans Administration researchers (Laska, Smith, Wislocki, Minami, & Wampold, 2013). In part, they wanted to investigate outcomes based on counselor characteristics. Data was used from an archival database of 192 veterans and 25 counselors who utilized a cognitive processing approach occurring between 2006-2009. The veterans completed the *PTSD Checklist*. Multilevel models helped evaluate specific counselor effects. Results suggested that effective counselor characteristics included flexibility, focus on the therapeutic alliance, the addressing of avoidance in clients, and genuineness. These speak to the facilitation of safety and indicate the importance of the counselor as a factor in effective trauma recovery (Laska et al., 2013).

Another study examined the role of the therapeutic alliance and outcomes in cases of PTSD related to child abuse. Trauma researchers Cloitre, Stovall-McClough, Miranda, and Chemtob (2004) developed a two-phase treatment protocol. The first focused on stabilization, with a similar purpose to Herman's focus on safety. They observed that most previous research focused only on measuring symptom change, failing to examine other variables such as the counseling relationship. Participants were recruited from two randomized PTSD trials. All participants were women and between the two trials, 34 completed treatment. Treatment consisted of a 16-week program following their developed protocol. Results suggested that the therapeutic working alliance was a significant factor related to positive outcomes in trauma survivors. Participants with a positive therapeutic relationship experienced a clear reduction in PTSD symptoms, further supporting the role safety plays as a foundation for recovery (Cloitre et al., 2004).

In the first study of its kind, psychology researchers Cronin, Brand, and Mattanah (2014) investigated the direct connection between the therapeutic alliance and work with clients experiencing dissociation. Data for this study was taken from a previous study of dissociative identity disorder (DID). Participants in that study included 132 patients diagnosed with a dissociative disorder. Their counselors were also invited to participate. A variety of measures were used and results indicated that patients who reported a greater alliance during treatment experienced fewer PTSD or dissociative symptoms as well as diminished general distress. Counselors rated these same patients as possessing higher adaptive functioning. In general, higher alliance ratings were associated with better outcomes. They concluded the establishment of safety was an important, foundational factor (Cronin et al., 2014).

Jacobson, Fox, Bell, and Zeligman (2015) focused their qualitative project on the perception of clients regarding what they deemed effective relative to their therapeutic treatment for DID. They investigated the effectiveness of counseling practices and counselor qualities. They analyzed semi-structured interviews using classical content analysis. Findings suggested effective practices included structure and pacing of sessions, a focus on coping skills, support, and sense of security. Specific approaches determined to be helpful included disclosure of insight, client-centered perspective, and attention to the therapeutic relationship. Approaches deemed ineffective included focus on technique, lack of safety, and lack of a plan. Specific qualities considered helpful were related to effective therapeutic alliances. For example, in this case qualities like empathy, genuineness, and positive regard were all identified as being effective. These findings stemmed directly from the perspective of the clients and placed the therapeutic alliance as the primary factor in terms of effective treatment and suggested an over-reliance on specific techniques may become an inhibiting factor (Jacobson et al., 2015).

It seems clear that stabilization is needed in the wake of trauma for a survivor to gain footing before progressing into the processing of events. Courtois and Ford (2014) emphasized the importance of the therapeutic alliance in trauma work. The formation of this relationship begins to reestablish trust that is often shattered. The role of the counselor in this and other stages of recovery is to offer clients encouragement for progress and growth. This requires the development of a strong, enduring therapeutic connection, especially in cases of complex trauma (Lewis, 1996). This establishment of safety and a return of control provides a stabilizing context for the facilitation of effective recovery.

Clinical Interventions: Remembrance, Mourning and Processing

Per Herman's (1997) model, a traumatic event itself is not the sole reason for its disruptive or positive impact. The way we process the event, along with related memories, becomes problematic or growth-oriented. She theorized that survivors strive to keep memories of the event out of awareness through use of defense mechanisms such as repression and denial. Dissociation may also occur (Suleiman, 2008). This results in the event not being integrated into consciousness, thereby giving it more power versus typical memory processes since "…they are not subject to the normal revisions and wearing-away processes of the mind" (Lewis, 1996, p. 8). They become the source of symptoms, therefore, the goal of counseling becomes reprocessing of the memories, feelings, and thoughts to integrate them, thereby allowing the trauma impact to be diminished or reframed as a learning opportunity (Lewis, 1996; Menselsohn et al., 2011). This reconstruction is central to the recovery process and is reflected in the volume of literature available that focuses on various qualities of this restorative work. Most of the research related to interventions, and primarily falling under the CBT umbrella, may be classified within Herman's second phase as characterized by direct engagement and processing of trauma.

German clinical psychology researchers Neuner et al. (2004) investigated the use of narrative exposure therapy (NET) with refugees. This approach is a combination of CBT and traditional narrative therapy. These researchers highlighted strong evidence supporting exposure and cognitive strategies for use with trauma survivors. They developed NET to allow survivors to repeatedly re-experience and subsequently work through trauma experiences and reconstruct fragmented narratives. Participants included 43 Sudanese refugees from a Ugandan settlement. Each participant had previously received a PTSD diagnosis. During the study, participants either received four sessions of NET (with psychoeducation included), four of supportive counseling, or one session of psychoeducation. At a one-year follow-up, 29% of NET participants met PTSD criteria, compared to 79% of the supportive counseling sample and 80% of the psychoeducation group. The researchers concluded the results were promising but more work is needed to understand the process. They also noted that limited research is available regarding trauma recovery in civilians exposed to war conditions (Neuner et al., 2004). The exposure aspects of treatment in this study paralleled Herman's emphasis on memory retrieval and reconstruction.

In another study focused on the narrative perspective, investigators based at the Israeli Center for Traumatic Stress examined the process of trauma recovery. They suggested the narrative approach invokes factors for effective coping including continuity and coherence, creation of meaning, and self-evaluation. They also noted the important interaction of cognitive processes. Data from this study were gleaned from a larger, longitudinal investigation and included the narratives of five men exposed to a terror attack. Narratives were examined at different points in time to assess developmental changes. Measures included The *Clinical Administered PTSD Scale*, *World Assumption Scale*, and a semi-structured narrative questionnaire. Results indicated a high degree of difference between narratives directly following

the trauma experience. In terms of development, they concluded the meaning-making process increased over time as participants became more stable. Findings also indicated lower levels of PTSD symptoms for those participants with well-developed, meaningful, and coherent trauma narratives. They suggested that people who are unsuccessful at integrating trauma, remain with a partial story, and are more likely to develop PTSD (Tuval-Mashiach et al., 2004). This view is consistent with Herman's notion of memory access, processing, and integration.

Cognitive approaches may also demonstrate long-lasting therapeutic gains. For example, in a follow-up to one study of PTSD by clinical psychologists based in the UK, participants reported an improved ability to manage their symptoms five years after counseling ended (Tarrier & Sommerfield, 2004). The researchers wanted to assess superiority and lasting treatment effects over time. Attempts were made to contact all participants of the initial inquiry. In that study, the sample consisted of individuals diagnosed with PTSD. They received either cognitive therapy or imaginal exposure treatments. A variety of assessments were used to evaluate outcomes. At the five-year follow up, ANCOVAs were used to compare differences between groups. Of those participants who received cognitive treatment, none met the full PTSD criteria at follow-up. This was compared to 29% in the imaginal exposure group. This difference was not present twelve months' posttreatment. The researchers suggested that may indicate cognitive approaches to be more enduring due to modifications of cognitions and substantive changes in beliefs. These results differed from previous research that indicated deterioration over time (Tarrier & Sommerfield, 2004).

University researchers Powers, Halpern, Ferenschak, Gilliham, and Foa (2010) demonstrated improvement over control conditions in a meta-analysis of 13 controlled trials with 675 participants that used prolonged exposure. They chose to examine exposure due to research

backing, empirical support, and established efficacy. All cases utilized a manualized exposure treatment protocol. Comprehensive Meta-Analysis indicated significantly better outcomes for participants treated with prolonged exposure as compared with a control group. However, efficacy was no better when compared with other treatments such as CBT or EMDR. The researchers concluded that clients treated with exposure therapy will have better outcomes than those treated with supportive counseling alone (Powers et al., 2010).

Psychiatry researchers Hinton, Rivera, Hofmann, Barlow, and Otto (2012) demonstrated how CBT may be culturally adapted for the treatment of traumatized refugees. Their review of the research indicated effectiveness of such approaches across cultural groups. They used available information to create a cognitive model to address a variety of symptoms common to trauma survivors. Components included a focus on trauma education, relaxation, cognitive reframing, affect regulation, and somatic symptoms among others (Hinton et al., 2012). Their model addressed many of the concerns discussed during the first two stages of Herman's model. CBT and related variants are demonstrated to be effective across a wide range of trauma types and speak to the need for addressing the unique, individual qualities of trauma survivors.

A study by Kallivayalil et al. (2013) explored the narratives of 14 trauma survivors. Participants were interviewed about their experience in trauma oriented, stage-based counseling. The purpose of the research involved learning what narratives revealed about their recovery, and examined any changes to their narratives over time. Interviews were conducted at the start of therapy and again eight months later. Analysis of the data used a grounded theory approach. These researchers discovered two primary themes. First, coherence in participants' narratives strengthened as they progressed through treatment. Second, participants became more reflective about their experiences. This was also true for their understanding of trauma causation and

impacted relational qualities (Kallivayalil et al., 2013). These shifts lend support to the second stage of Herman's model, which calls for greater memory access to trauma experiences. Ultimately, this process is empowering as clients develop new meanings.

To address the needs of violent loss survivors, crime victim researchers Saindon et al., (2014) developed a more targeted, structured type of narrative therapy termed restorative retelling. They suggested that goals of this approach include improvement of coping skills, integration of commemoration, and processing of trauma memories. Fifty-one participants for the study were taken from a records review open trial that yielded a final sample of 51. They participated in ten weekly sessions of restorative retelling. Measures included the *Beck Depression Inventory*, *Impact of Events Scale*, and *Inventory of Traumatic Grief*. ANOVAs were conducted for analyses and findings suggested this approach resulted in a significant reduction of symptoms related to depression, avoidance, and prolonged grief (Saindon et al., 2014). This approach primarily emphasized the work of Herman's second stage but also included elements of stabilization and reconnection as it was conducted within a group context, thereby providing safety and opportunities for connection.

In a meta-analysis of treatment approaches, an international team of psychology researchers (Ehring et al., 2014) investigated effectiveness with adult survivors of childhood sexual and physical abuse. Included studies had to meet several specific criteria, producing 16 randomized controlled trails for analysis. Coding was related to treatment characteristics and methodological quality. Effect sizes were also calculated. Results indicated trauma-focused CBT to be effective, with moderate to large effect sizes along with reductions in depression, anxiety, and dissociation. Trauma-focused treatment was also deemed to be more effective than non-trauma approaches. These researchers concluded that individual trauma-focused counseling was

effective in treating PTSD symptoms, a finding supportive of previous research (Ehring et al., 2014).

CBT is also useful following natural disasters. An interdisciplinary team of researchers in Brazil investigated the efficacy of CBT is such cases (Lopes, Macedo, Coutinho, Figueria, & Ventura, 2014). They noted that natural disasters impact 225 million worldwide annually with an estimated 13,500 million developing PTSD. They conducted a systematic review of published studies related to individuals diagnosed with PTSD following a natural disaster. These included a variety of study types that utilized CBT for treatment. These criteria yielded 11 studies totaling 742 participants. An analysis of methodological quality suggested strong support for the effectiveness of CBT and exposure techniques with earthquake survivors, like previous studies. They concluded that exposure approaches are an effective PTSD treatment. The authors did note several limitations in the study, including a singular emphasis on earthquakes, and discussed the need for further investigation (Lopes et al., 2014).

In a study of women who experienced intimate partner violence, Beck et al. (2016) sought to replicate and expand previous research that suggested trauma-focused cognitive therapy models are effective for reducing symptoms associated with PTSD and depression. Participants of the study included eight women who met the DSM-IV diagnostic criteria for PTSD because of partner violence experiences. Treatment was comprised of 90-minute sessions for 11-12 weeks that specifically targeted guilt and self-blame. A variety of measures were used including the *Post-Traumatic Checklist*, *Beck Depression Inventory II*, *Beck Anxiety Inventory*, *Rosenberg Self Esteem* scale, *Quality of Life Inventory*, *Trauma Related Guilt Inventory*, and *Internalized Shame Scale*. MANOVAs indicated a significant reduction of trauma symptoms as measured at pre- and post-treatment with large effect sizes. Additionally, anxiety and self-esteem

improved during treatment. These researchers concluded cognitive based trauma treatments to be effective with this population. They did call attention to the small sample size and suggested results may differ across various populations (Beck et al., 2016).

The breadth of this literature review across a variety of scenarios using multiple approaches lend support to Herman's assertion that the nature of the recovery process is one of remembering, reworking, and reintegration. The client must be able to tell their story (Herman, 1998). The desired result is empowerment (Lewis, 1996), while the counselor serves as "witness and ally" (Herman, 1997, p. 175). This is accomplished when the client "…reclaims her own history and feels renewed hope and energy for engagement with life" (Herman, 1998, p. S148). Manda (2015) recognized reconstruction and reintegration occurs because of feeling heard. Once this trauma work is under way, clients may begin working on the process of reconnection, discussed next.

Clinical Interventions: Reconnection

A focus on relationships, or connections, are important as Herman suggested recovery based on insight alone is inadequate (Herman, 1997). While this need for reconnection is important during all stages, it expands and takes on a social quality during the last phase of recovery. Work during this stage involves reeducation regarding normalcy, the gaining of perspective, the incorporation of learning gained from the trauma experience, reestablishment of relationship intimacy, renegotiation of boundaries, and a redefinition of self (Lewis, 1996; Menselsohn et al., 2011). This allows for the restoration of damaged, internal aspects of the self (Herman, 1998). Fewer examples are available in the literature regarding this process.

In work with cancer patients and stress disorders, psychology researchers Petersen, Bull, Propst, Dettinger, and Detwile (2005) found those who engaged in meaning-making processes

early in treatment had better outcomes. They argued that cognitive approaches are effective, but a narrative approach may be more useful in addressing the concerns of the whole person. The process works because clients are better able to remember "…neglected parts of their experience, [and are] able to formulate a more complete story of their experience" (p. 42). This focus on memory and processing is consistent with Herman's second stage of recovery. They described a three-session cancer recovery program that focused on integration through narrative development as informed by available research. They suggested that facilitative qualities of such narrative approaches include connection, engagement, exploration of core human themes, and the personal expression of those themes (Petersen et al., 2005). The focus on the whole person in this work extends into and speaks to Herman's third stage through its emphasis on connection with others.

The purpose of one study by the international team of children's services and trauma researchers Brand et al. (2012), was to more closely examine expert perspectives on important aspects of treatment approaches. While several models have been developed, there are no empirically supported intervention criteria, lending to many differences of opinion regarding treatment issues. They reiterated three common phases of treatment for PTSD that parallel Herman's (1997) model. During the final stage, a priority is placed on goals and meaning-making. Participants included 36 purposively sampled therapists known for their work with DID. Participants completed an online adaptation of a survey from a previous DID treatment outcomes study and the *Treatment Activities with Dissociative Disorders* measure. Statistical analyses were not used due to the small sample size. Results indicated most therapists emphasized, 1) safety strategies, 2) daily functioning skills, 3) psychoeducation, and 4) work on distorted cognitions during the first two stages. These continued into stage three while including work on emotional regulation and aspects of dissociation. The recommendations of these researchers were consistent

with stage models and current treatment guidelines. In fact, they appeared to approach a core process given the commonality among participants. Consistency was strong during the initial stages and decreased during treatment, indicating a need for more specificity in guidelines (Brand et al., 2012). This focus on emotional regulation is important as there are functional implications suggested relative to social engagement.

MLAC Institute for Psychosocial Services researcher Parr (2015), used play and expressive arts with 39 survivors of Typhoon Yolanda in the Philippines. The approach also included aspects of mindfulness and cognitive therapy. This inquiry used a qualitative, multiple case study design to consider narratives generated individually and within a group setting. Data were analyzed using a clinical judgment and discussion consensus model. Results included the development of themes and narratives that were restorative and increased self-awareness. The theme of "A New Beginning" was developed and reflected on by the group. Based on a family collage activity, themes of unity and transcendence emerged. The researchers emphasized the social aspect of trauma and the "…basic need of being reaffirmed as an integral part of a whole…" (Parr, 2015, p. 149). The use of groups in this study was consistent with the suggestion of Menselsohn et al. (2011) and findings supported Herman's assertion of the need for social connection and sense of continuity as critical aspects of trauma recovery. Ultimately, the expressive arts approach became "…a therapeutic tool in the way that it helps survivors understand their own experiences. This allows them to reframe their stories in a way that has meaning to them." (Parr, 2015, p. 140). It also allowed for self-expression in a unique, individualized manner. The researchers concluded by suggesting more research needs to be conducted on various expressive arts modalities as used for trauma recovery.

A researcher from the Research Institute for Theology and Religion studying survivors of political violence in South Africa also provided evidence for a more holistic response to trauma with the inclusion of spirituality in survivor narratives. It was noted that most research has focused on bio-psycho-social areas. This longitudinal, participatory action study examined narratives in Pietermaritzburg from 2009-2013. After screening, 33 participants completed the *Harvard Trauma Questionnaire*. Participants were guided through phases of treatment that ended with narratives being documented and published. Textual analysis revealed themes related to moral and spiritual injuries in addition to those categorized as bio-psycho-social. It was argued this traditional framework is inadequate for understanding the impact of trauma on the whole person (Manda, 2015). The need to reconnect with the moral and spiritual self is consistent with Herman's final phase.

Clinical Interventions Summary

The preceding information was organized in relationship to Herman's (1997) three-stage recovery model. The research literature provided several examples of approaches consistent with and supportive of the processes described. Interventions used may be dictated by the position of client needs relative to these three phases (Herman, 1998). The research history also reflected how clients vacillate between what Herman (1997) described as the conflict between the denial of their trauma experience, and the profound need for expression. Therefore, it is important to note like most stage theories, that these phases do not unfold as neatly as presented. They are not discrete and often overlap (Lewis, 1996; Menselsohn et al., 2011), meaning issues may need to be revisited during different phases. Clients are responsible for their recovery and the basic outcome is the understanding that it "…is not based on the illusion that evil has been overcome, but rather on the knowledge that it has not prevailed…" (Herman, 1998, S. 149).

Researchers in many cases noted limitations with methodology and the need for more research. This is especially true of knowledge related to specific populations. Also, in many cases it is difficult to evaluate the efficacy of counseling approaches due to the variety of approaches available and a lack of standardized treatments (Neuner et al., 2004). However, research related to risk and resiliency in trauma survivors underscored factors that support effective coping (Vernberg et al., 2008). Currently, Briere and Scott (2015) recommend the utilization of a variety of interventions and theoretical orientations as called for by the given client and clinical situation. They identified a variety of common factors for effective therapeutic intervention of trauma including attending to the therapeutic relationship, providing emotional, interpersonal, and cognitive support, and moving toward self-awareness and growth-oriented activities. All these suggestions are congruent with various aspects of Herman's model.

Despite the research conducted in this area, knowledge regarding the nature of coping is still lacking (Tuval-Mashiach et al., 2004) as well as information regarding interventions targeted at specific populations, such as violent loss survivors for example (Saindon et al., 2014). While the breadth of evidence seems to support the general process of recovery, more work is needed relative to understanding specific, individual factors. In particular, the use of expressive arts approaches as related to individual trauma recovery in adults seems underdeveloped.

The Expressive Arts as Therapy

Expressive therapies incorporate aspects of music, art, dance, poetry, and other creative activities into the counseling process. Humphrey (2009) suggested, "they provide an active, experiential, and highly idiosyncratic means of helping clients encounter, express, and explore their issues and concerns" (p.129). For example, Irwin (1991) noted that drawing serves to help clients tell stories they have difficulty putting into words. Drawing also serves as a means for

meaning-making with diverse groups such as those with learning disabilities (Humphrey, 2009). Similarly, research on writing demonstrated that the ability to construct a coherent story relates to improved coping (Tuval-Mashiach et al., 2004). Others reported that writing helps clients regain control (Garrido et al., 2015). The value of these approaches lie in their ability to accommodate various communication styles or even provide alternative forms of communication (Malchiodi, 2005) across the full spectrum of human development (Rogers, 2011). Ultimately, these approaches become "…a therapeutic tool in the way that it helps survivors understand their own experiences. This allows them to reframe their stories in a way that has meaning to them." (Parr, 2015, p. 140).

Expressive approaches also prove to be versatile. Programs developed by music therapists were used with survivors of the September 11, 2001 terror attacks in New York City and focused on stress reduction, coping, and processing (American Music Therapy Association, 2011). Davis (2010) conducted a case study with pre-adolescent tornado survivors. Musical compositions were created that allowed the children to better express their feelings as they learned to manage their emotions and return to school. Rappaport (2010) developed a focused art therapy approach structured for use with Herman's three-stage recovery model. His stepwise approach followed the progression of her model. For example, during the safety phase as clients work to establish new boundaries, the counselor might have them draw a safe place followed by reflection. As clients begin working through trauma they may construct visual representations of the trauma they experienced. Finally, clients may continue to dialogue with art as they strive to reconnect with the present. Winn (as cited in Bannister, 2003) demonstrated effective use of drama therapy for addressing PTSD in police and other emergency personnel. Some support of positive expressive arts outcomes exists for use with survivors of torture (Gray, 2011). Finally,

Malchiodi (2005) suggested that the use of expressive arts may aid in addressing emotional constriction, memory, and problematic cognitions. These examples, while limited, demonstrate promise across a variety of trauma types.

The expressive arts also allow clients to test different ideas and behaviors (Gladding, 2011). Authors argued that the arts may be effective because they facilitate access to negatively impacted brain areas and functions such as images, emotions, and cognitive processes (Lusebrink & Hinz, 2016). Others suggested they play a role in accessing our internal resources for healing (Parr, 2015). Yet, the arts have received little attention as an intervention during trauma recovery in adults (Clift, Camic, & Daykin, 2010). And even though numerous expressive mediums have been explored by practitioners, there is a need for empirical evidence regarding their utility as currently, little understanding of the precise processes at work exists (Garrido et al., 2015). Most of the research focuses on expressive arts creation facilitated by clinicians, rather than artistic expression enacted solely by the trauma survivor. While tattoos are not an expressive art in the traditional sense, the connection is argued because, 1) clients may be part of the creative process as they work in collaboration with the artist or others in terms of design, placement, and other factors and 2) it becomes a form of individual expression (Dadlez, 2015). As an activity selected by some adults, questions remain about the possible connection with the recovery and growth process following trauma.

Tattoos: The Etching of Identity into Skin

The meaning of *tattoo* is derived from a Polynesian word representing to mark or strike, and evidence of the practice may be traced back to 6000 BC (Bhargava, Singh, & Kumari, 2016) or earlier (Post, 1968). Tattooing as we know it today, "…by introduction of dyes or pigments into the skin by puncture was known in ancient Egypt between 4,000 and 2,000 B.C." (Post,

1968, p. 517). Tattoos are also found among Egyptian mummies (Favazza, 1996). Other evidence of tattoos may be found in many early cultures including Greece, Persia and Japan and are considered "…important and serious aspects of communal living, assuming religious, magical, and social significance" (Ferguson-Rayport, Griffith, & Straus, 1955, p. 113). During the fifteenth century, Europeans traveled equatorial countries observing a variety of body modification practices, including tattooing, and brought them home (Zeiler & Kasten, 2016). Speculation on the psychological significance of the practice may be traced to Captain Cook's observations of Tahitian men in 1771 (Measey, 1972), engaging in a practice he coined *Tattaw* (Post, 1968). During the early Christian era, tattooing was viewed unfavorably due to biblical injunctions (Jablonski, 2013). The first tattoo shop opened in London during 1870, followed by the first patented tattoo machine in 1891. The practice expanded at the end of the Victorian era as facial painting prohibitions were lifted. And as they are permanent, governments have used them for branding, the most notable example being Nazi concentration camp identification numbers (Favazza, 1996).

Currently, tattoos have made their way into mainstream society (Home, Knox, Zusman, & Zusman, 2007). Tattooing has proliferated over the last three decades with as estimated 3-9% of the general United States population having at least one (Bhargava et al., 2016), and as many as eighty million people inclusive of all industrialized countries (Jablonski, 2013). These numbers continue to increase across a wide range of demographic variables (Dickson, Dukes, Smith, & Strapko, 2015). As such, growing attention exists regarding their personal and social significance.

Much of this consideration comes from a few notable figures in sociological and anthropological circles of academia. Sanders (1988) suggested that tattoos possess implicit and

explicit meanings that are reflected in our identity and aid self-expression. He noted they may also be linked to religious and spiritual beliefs, thus intimately connected to the self. Hewitt (1997) explained that body mutilation represents individualism and may serve the function of death and rebirth. Sweetman (1999) agreed that tattoos anchor the unique self and serve as a form of individual expression, allowing people to tell their stories. Through numerous interviews within the tattoo community, DeMello (2000) illustrated how tattoos are connected to our culture and become self-empowering. She believed that tattoos meet the changing demands of the bearer and are thus tied to individual meaning-making. She concluded tattoos articulate who we are in unconventional, deeply meaningful ways. Atkinson (2003) argued that tattooing now represents a normative and meaningful way for expressing individualism, life events, and personal growth. He also believed they serve as a positive means for reflecting on and communicating our identity.

The fact that our very bodies become the canvas for this practice has also received attention. Favazza (1996) argued, while the skin is a simple organ, it holds significance within a social and psychological context; "the skin is a border between the outer world and the inner world, the environment and the personal self" (p. 148). He concluded that aspects of the skin reflect our identity and internal states. For example, the skin is the location for self-mutilation, a marker for significant inner turmoil. Tattooing itself may be deemed a form of self-mutilation depending on motivation and is hypothesized as being a form of psychological defense (Favazza, 1996). In a sense, skin serves as a highly visible vehicle for communication (Jablonski, 2013). The tattoo bearer may use skin "…as an invitation to the internal self" (Acharya, 2013, p. 16).

Of course, not everyone obtains a tattoo. This naturally leads to the questioning of what personal, social, and motivational factors are involved (Post, 1969). Three broad categories

emerged in the literature relative to mental health and tattooing: criminal associations, deviant behavior, and individual meaning-making. These areas are explored next with a review of studies related to each.

The Tattoos of Incarcerated Individuals and Gang Members

Some of the earliest empirical studies of tattooing involved prisoners. DeMello (1993) observed that prison tattoos are a distinct form that are easily recognizable from those done by professional artists. She also noted they serve a social role, marking identity, status, and boundaries. Others believed tattooing reflected primitive traits held over and expressed among criminals and the lower class (Favazza, 1996). Other identified reasons include aesthetics, externalization of defining qualities, and communication (Snopek, 2015). In an environment where all possessions and liberties are removed, they often represent autonomy and community membership (McNaughton, 2007).

Sociology researchers Phelan and Hunt (1998) studied the role of tattoos in the identity development of prison gang members. They noted, "…identity does not just happen. Rather, identity is an ongoing process that emerges from individuals' interpretive and communicative efforts" (p. 278). An inductive, grounded theory approach was used in this study, focused on the Nuestra Familia gang tattoos. The Nuestra Familia is a structured organization that formed at San Quentin in 1968 and draws membership largely from Northern California. Phelan and Hunt (1998) collected data through full participation in the California State prison system over six years. A variety of data and documents were collected during this period, in addition to daily observations involving hundreds of prisoners. This data was interpreted along with sketches. Tattoos were found to relate to five phases of gang development, including: pre-initiate, initiate, member, veteran, and superior. They seemed to reflect the past as well as indicate future

aspirations (Phelan & Hunt, 1998). In an environment of limited resources, they became a means for communicating identity and place.

Research also focused on the connection between tattoos and psychopathology in incarcerated individuals. Psychology researchers Manuel and Retzlaff (2002) completed a study of 8,574 male inmates from the Colorado Department of Corrections. The *MCMI-III Corrections Version* was used for assessment. Tests were administered during admission and compared to tattooing infractions noted in disciplinary records for the following two years. They found several troublesome personality types associated with the practice of tattooing including antisocial, sadistic, negativistic, and borderline. Clinical diagnoses of those with tattoos included mania, PTSD, drug abuse, and thought disorders. In addition to these associations, they concluded tattoos may also function as a form of defense and symbols of affiliation within a very difficult and aggressive environment (Manuel & Retzlaff, 2002). Here again, tattoos appeared to communicate aspects of identity.

Recent research examined the association of tattoos with endorsement of a criminal lifestyle. University psychology researchers Lozano, Morgan, Murray, and Varghese (2011) questioned risk of recidivism, greater instances of convictions, and behavioral problems in prisoners. Participants included 208 adult male inmates and a comparison group of 66 adult male college students. Samples of the inmate participants were broken into two groups based on prison or non-prison oriented or themed tattoos. Assessments utilized included a tattoo history questionnaire, the *Psychological Inventory of Criminal Thinking Styles*, and the *Self-Appraisal Questionnaire*. A multivariate analysis of covariance indicated that the group with prison themed tattoos displayed aspects of the criminal lifestyle not seen in the rest of the participants. They were also deemed a greater recidivism risk and tended to blame others for their problems

(Lozano et al., 2011). This further supported the connection to identity by demonstrating an association between behavior and type or theme of bodily inscription.

The utility of tattoos in the prison setting seems to be shifting in parallel with their changing social status. Snopek (2015) argued tattoos in prison are evolving as their artistic merit continues to be recognized by the larger society. He suggested that prison tattoos often serve as aesthetic, unique expressions of the bearer. Still, they remain highly symbolic. Among gang members, tattoos are associated with membership, rank, and accomplishments (Jablonski, 2013; Phelan & Hunt, 1998). Prison tattoos represent the culture, identity, and uniqueness of the bearer as well as challenge to the system (DeMello, 1993). Tattoos allow incarcerated individuals to express values in one of the only ways they can (McNaughton, 2007).

Walters (1990) surmised that tattooing may be one result of the criminal personality characterized by thinking distortions, rationalizations, immaturity, and self-indulgence. Zeiler and Kasten (2016) acknowledged a history of prejudice linking tattooing with criminal behavior. This association of tattoos with deviant behavior has been the prevailing theme of research with non-incarcerated individuals, and is discussed next.

A Marker of Risk or Psychopathology?

The largest body of empirical data available relative to psychological aspects of tattooing comes from investigations linking the practice to deviant behavior (Davidson, 2016). Tattoos were once associated with the lower class and groups such as sailors and prostitutes (Bhargava et al., 2016). In nineteenth century Japan, tattoos were used in part as punishment and placed on the faces of criminals (Favazza, 1996). Parry (1934) was among the first mental health practitioners to question the practice of tattooing and believed it to be the province of "prostitutes and perverts" (p. 476). These are perhaps some of the reasons tattoo research seems to be skewed

toward problematic mental health issues and deviant behavior. Most studies suggest links to high risk behaviors (Bhargava et al., 2016; Manuel & Retzlaff, 2002; McNaughton, 2007; Zeiler and Kasten, 2016). However, there is now recognition that different types of tattooing may be linked to different social classes (DeMello, 1993) and personality types (Manuel & Retzlaff, 2002), thereby expanding our view of their relationship to behavior.

Ferguson-Rayport et al. (1955) conducted one of the earliest studies examining a direct link between tattoos and personality issues. During a seven-month period, they studied patients with tattoos who were admitted to the Veterans Administration Hospital in Lexington, KY and diagnosed with Personality Disorder or Schizophrenic Reaction. Of 232 neuropsychiatric admissions, 16% (n=37) had tattoos. Fifty-seven percent (n=20) of those with tattoos had a diagnosed personality disorder. Assessments included photographs, standardized interviews, and social histories. A focus was also placed on the nature of the tattoos as well as reasons for acquisition. Ferguson-Rayport et al. (1955) found these patients had multiple tattoos as compared with a control group. The tattoos focused on themes such as pornography, sentiment, and pseudoheroism. Schizophrenic patients had tattoos with idealistic and magical themes. They concluded that tattooing is a practice that allows for reflecting upon oneself, with differences existing relative to personality and internal states.

An early review of the literature also focused on the direct link between tattoos and personality disorders. Police science researcher Post (1968) clearly stated his purpose was to demonstrate this connection in hopes of having another predictor or indicator of potential problematic behavior. He discussed several motivational factors and cited early Naval research that suggested those with tattoos demonstrated unresolved sexual and aggressive conflicts along with other maladjusted behaviors. He also cited research that connected those with tattoos to a

variety of criminal activity. Because of this review, Post (1968) concluded those with tattoos are likely to hold specific self-concepts. Further, he believed these self-concepts represented a negative orientation to the social world which led to the subsequent development of personality disorders.

Another early study by UK psychiatrist Measey (1972) of sailors admitted to Royal Naval Detention Quarters found a positive correlation between instances of personality disorders and number of tattoos. Participants included 400 sailors who entered service between November 1969 and May 1970. Assessments were completed with a social history questionnaire and a structured interview regarding reasons for tattoo acquisition. Clinical assessments of personality disorders were also conducted. Of the participants, 247 had tattoos. Tattoos fell into a variety of categories and quantities. Personality disorder rates were found to be 48% (no tattoos), 58% (1-4 tattoos), 64% (5-9 tattoos), 70% (10-15 tattoos), and 82% (more than 16 tattoos). Measley (1972) discovered getting a tattoo was a rite of passage before leaving for service which likely accounted for much of the sample having tattoos. He also suggested increased instances of personality disorders in those with a higher number of tattoos or as related to tattoo placement (hands and face). Interestingly, those with personality disorders also possessed a more positive attitude toward their designs. This study suggested an association between increased body art activities and personality issues.

Most recent research also tended to explore the connection between tattooing and psychological problems. Adolescent medicine researchers Roberts and Ryan (2002) examined the prevalence of tattoos as an indicator of high risk behavior. The study method included a secondary analysis of the National Longitudinal Survey of Adolescent Health. This was a national survey of 11-21 year olds and participants included 6,072 adolescents. Of this sample,

4.5% reported having a tattoo. Significant associations found in those with tattoos included older age, single-parent household status, and lower socioeconomic status. Other significant associations found included substance use, early sexual behaviors, violent behavior, and problems in school (Roberts & Ryan, 2002). They concluded there is a clear link between tattooing and high risk behavior, and the presence of a tattoo indicates cause for further assessment and counseling considerations.

A later study also examined the connection of tattoos to deviant behavior in adolescents as a matter of public policy. Taiwan university researchers Liao, Chang, and Su (2014) surmised that engagement in high risk activities leads to other high risk involvement, and tattooing should be considered high risk as it carries possible health consequences. Data obtained included information culled from 973 adolescent detainees in Taiwan. Instances of criminal behavior associated with tattooed and non-tattooed individuals among the detainees were analyzed by using *t*-tests. Results indicated a significantly greater likelihood to commit fraud (3%), assault (13%), drug abuse (9%), and homicide (9%) in those with tattoos. However, no notable association was found in property crimes (larceny and robbery). Liao et al. (2014) concluded their research demonstrated that the presence of a tattoo may serve as a predictor of probable criminal acts.

Health researchers King and Vidourek (2013) studied the link between tattoos and high risk behavior in college students. Participants included 998 students enrolled in physical activity and health classes, of whom, 29.6% had a tattoo. Assessment consisted of a 44-item survey about tattoo behavior based on available research and collaboration with tattoo artists. Data analysis focused on between-group health behavior differences using Chi-square and analyses of variance. Results indicated that those with tattoos were significantly more likely to engage in

behaviors such as alcohol use, marijuana use, and high risk sexual practices. No significant differences were found relative to suicidal behavior. They also found that more women get tattoos than men, perhaps signaling different societal expectations related to gender (King & Vidourek, 2013). These researchers concluded the study corroborated previous findings demonstrating a link between tattoos and deviant behavior.

Only a few studies challenge the perspective that tattooing and deviant behavior are related. Canadian psychology researchers Nathanson, Paulhus, and Williams (2006) investigated personality, misconduct, and cultural deviant markers such as tattooing. Participants included 279 (70% women) undergraduate university students and factors considered included peer group membership, personality traits, self-esteem, and the "dark triad" of personality disorders (narcissism, Machiavellianism, and psychopathy). The researchers used numerous instruments to assess cultural deviance markers. Correlational results suggested that the acquisition of deviance markers such as tattoos was not associated with increased misconduct, except for drug use (Nathanson et al., 2006). They concluded, while further research is needed, stereotypes of such practices should be replaced with curiosity about their significance for individual bearers.

In another study of college students, sociology and nursing researchers Koch, Roberts, Armstrong, and Owen (2015) questioned the relationship of tattooing behavior with gender and general well-being. Purposeful sampling from six United States public universities yielded 2,395 respondents. Well-being was measured with scales developed from literature relating to self-esteem, depression, and suicidal ideation. Results suggested a four times greater rate of suicide attempts in women participants who had four or more tattoos versus those in the sample with fewer. However, higher levels of self-esteem were also reported by that same group (Koch et al., 2015). They surmised this may be accounted for by attempts at emotional restoration, an aspect

of this behavior discussed later. No other differences were found significant in this study. Along with the previous study, these results point to potential positive aspects of tattoo acquisition.

The most current research also examined the link between tattoos and behavior. Austrian researchers Swami et al. (2015) questioned the stereotype that suggests people with tattoos tend to be more aggressive and rebellious. They argued that little recent research exists examining behavioral distinctions of those with tattoos, and the data we do have is unclear. Participants in their study included 378 adults; 25.7% of this sample had at least one tattoo. They relied on self-reported data regarding tattoos and utilized the *Aggression Questionnaire* and *Rebelliousness Questionnaire* to assess behavior. Results indicated that those with tattoos exhibited higher reactive rebelliousness, anger, and verbal aggression. However, the researchers cautioned against making assumptions about how this might manifest in the real world. Effect sizes were also small and there were no significant between-group differences in terms of proactive expressions of these same behavior types. They concluded, while there may be some truth to the common view of a link between aggression and tattoos, the stereotype likely represents an outmoded view, and the two groups are more similar than they are different (Swami et al., 2015).

Another study considered tattoo stereotypes while investigating differences in intelligence and creativity. German medical researchers Cebula and Kasten (2015) recognized that prevailing stereotypes of tattooed people include alcohol and drug use, risk taking, and lower levels of intelligence. They interviewed 104 college students with nearly half possessing at least one tattoo. Assessments included a social history, the *Multiple-Choice Vocabulary Intelligence Test*, and five subtests of the *Questionnaire for Divergent Thinking*. Results indicated no significant between-group differences related to intelligence or creativity. Thus, they concluded

that stereotypes regarding lowered intelligence in tattooed people are unfounded (Cebula & Kasten, 2015).

Similarly, German medical researchers Zeiler and Kasten (2016) noted the prejudice relative to those with tattoos and sought to examine differences in behavior. Participants included 110 individuals between the ages of 19-46. Of those, 50 had at least a single tattoo. Results indicated the nature of the tattoo was a more significant factor in the likelihood of criminal behavior, rather than simply their presence (Zeiler & Kasten, 2016). In other words, those with tattoos categorized as aggressive were more likely to engage in the assessed behaviors.

The connection of tattoos with unseemly personal qualities or disrupted mental health remains persistent. Raspa and Cusack (1990) concluded there was a direct link between mental issues and tattoos, enough to suggest "…finding a tattoo on physical examination should alert the physician to the possibility of an underlying psychiatric condition" (p. 1481). Even with their increased popularity, published research largely continues to suggest a link with maladaptive behavior and emphasizes that caution should be considered when one notes a tattooed individual (King & Vidourek, 2013; Koch et al., 2015; Liao et al., 2014; Nathanson et al., 2006). Zeiler and Kasten (2016) realized that we make quick conclusions about others, and that such categorization leads to prejudice since tattoos may not meet others' expectations. Furthermore, Bhargava et al. (2016) observed that the practice of tattooing has moved from a marker of deviance and stigma to one of accepted expression. Still, they argued that there is a strong link between tattooing and high risk behaviors in the literature. The mixed nature of these research findings establishes the need for further investigation.

Many of the early investigations carried out in this area were conducted in institutional contexts (Ferguson-Rayport et al., 1955), hindering generalizability. Additionally, many of the

more recent studies focused on adolescents and college students. Given this developmental period, it is possible many other confounding variables are at play. Perhaps age and developmental processes along with personality are important considerations. For example, Irwin (2003) suggested a categorical divide between risk taking adolescent tattoos and positive self-expression tattoos in adults. The emerging research data seems to indicate a need for more research regarding the nature of a person's tattoos and reasons for acquiring them (Zeiler & Kasten, 2016). This area of curiosity represents the third main body of investigation discussed next.

Purpose and Meaning: Motivational Aspects of Tattoo Acquisition

As the previous overview suggests, even with greater acceptance in society, tattoos from a social science perspective carry a heavy association with deviance (Nathanson et al., 2006). Currently, tattooing has received more attention in pop culture and the media than it has as a subject of scientific study. The remaining body of research generally lacks cohesion and considers a variety of related aspects such as motivation and meaning-making. As a precursor to this line of inquiry, researchers conducting investigations into other areas noted several observations. For example, tattoos often connect to religious and spiritual practices. Post (1968) noted several accounts such as Yugoslavian women protecting themselves from evil by placing a cross on their foreheads or seafarers who mark themselves with certain images to protect against death. Aesthetics and fashion may serve as possible motivations (Measey, 1972). Other earlier studies suggested a connection between individual decision-making and the relationship of tattoos to individual life experience (Sanders, 1988). Tattoos also may serve as a means for taking control of our bodies as we have a hand in their design (Richardson, 2006). Reasons for obtaining a tattoo mentioned in the King and Vidourek (2013) study included self-expression,

desire, fun, and adventure. Others identify expression of protests against society and authority or connection to significant others (Cebula & Kasten, 2015). Finally, Bhargava et al. (2016) argued, "the ultimate purpose of tattooing has always been identification" (p. 857). Therefore, there are likely other reasons beyond deviance for why people obtain a tattoo.

Home et al. (2007) studied characteristics of tattooed college students. Participants consisted of 400 non-randomly sampled students; over a quarter (27.5%) possessed a tattoo. They were asked to complete a 52-item questionnaire developed to assess attitudes toward tattoos and piercings. Cross-classification was used to determine significant relationships between categories. Over 90% reported personal reasons for getting a tattoo versus trying to impress others. The study also observed important gender differences including decorative motivations for women and group identity for men. Women also possessed greater awareness that meanings associated with their tattoos may change over time, reflecting an overt connection with personal identity, and a symbolic representation of the self (Home et al., 2007).

Fashion and design researchers Mun et al. (2012) examined meanings given to tattoos and how they influenced behavior and self-perceptions. They conducted a phenomenological investigation to learn about the association of tattoos with the construction of self. They hypothesized that tattoos may communicate aspects of who we are, or who we want to be. Purposive sampling resulted in 30 women participants between 18-38 years of age. Findings revealed that most of the participants spent time carefully planning their tattoos. Results produced several themes related to meaning including, 1) connection to self and a way to express personal values and interests, 2) remembering important life events, 3) signifying important relationships, 4) spiritual reflection, or 5) no specific meaning (Mun et al., 2012). Eighty-two percent of the participants discussed how their tattoos reflected some aspect of who they are.

Some participants also talked about dissatisfaction as their tattoos no longer represented their current identity, supporting previous research suggesting a connection to the self. Sixty-one percent reported that meanings change over time and another 30% discussed confidence gains and other changes to self-perceptions. These researchers concluded that tattoos hold dynamic meanings and that participants regularly monitored tattoo meaning to ensure consistency (Mun et al., 2012). This behavior supports a close connection with personal identity.

Another recent study examined symbolic meaning-making in tattoo choices among college students. Dickson et al. (2015) argued that tattoos become identity markers and serve to creatively reveal and communicate oneself to others. Participants included 458 undergraduate students with an age range of 15-59 years. Of this sample, 195 (43.1%) had at least one tattoo. Non-tattooed participants completed a questionnaire assessing reasons for not having a tattoo while tattooed participants completed a descriptive assessment of their reasons and experiences. Results indicated role transitions as an important factor in obtaining a tattoo, supporting a connection to identity and self-expression (Dickson et al., 2015). Participants identified tattoos as a symbolic way to communicate personal growth and significant relationships. Among those not tattooed, reasons included concerns over permanency, lack of a purpose for obtaining one, and health worries. Dickson et al. (2015) concluded that tattoos serve as a meaning-making process connected to the self and disputed the oft found association with deviant behavior.

It seems many similarities exist in the general public as compared with the aforementioned prison tattoo population (Phelan & Hunt, 1998). For non-incarcerated individuals, tattoos also appear to serve communicative aspects of the self. However, the review of this area revealed, empirical data regarding motivations for tattooing is limited and mixed or ambiguous (Cebula & Kasten, 2015; Bhargava et al., 2016; Dickson et al., 2015; Pajor,

Broniarczyk-Dyla, & Świtalska, 2015; Roberts & Ryan, 2002; Swami et al., 2015), making their significance difficult to determine from a clinical standpoint. Motivations are varied, and there may be additional reasons for choosing to acquire a tattoo. For example, they may also "…memorialize an event, a person, a relationship, a death, or a period…" (Richardson, 2006, p. 72) in life. The recognition that they may serve as a memorial is discussed next as an emerging body of research.

Tattoos: The Connection to Trauma

While there is information available about the psychology of tattooing, much less is known from a scientific standpoint regarding a potential connection to traumatic experiences such as death and loss. Some hypothesize that we must return to and work through a traumatic experience to fully incorporate the experience into the self, and tattoos may serve as a symbolic means for doing that work (Sarnecki, 2001). Atkinson (2003) argued that tattoos may perform the important role of affect management, which allows individuals to cope with pain, stress, and loss in a controlled manner. He suggested that tattoos may serve as a memorial and the act of getting one itself is a symbolic exorcising of pain related to loss. Further, they may "…represent an effort by individuals to set their trauma in time and place" (Gentry & Alderman, 2007, p. 196). One study directly examined the presence of tattoos and a history of abuse. Results indicated that a history of physical, mental, and sexual abuse was highly associated with subsequent body modification (Liu & Lester, 2012). This suggested a possible therapeutic function. In the Manuel and Retzlaff (2002) study, the researchers suggested prisoners may be using tattoos to cope with trauma, based on the PTSD scale assessment results. However, they offered no further elaboration. Snopek (2015) also indicated sense of loss as a common reason for prison tattoos. Finally, Mifflin (2013) documented accounts of tattoos used in therapeutic

ways by women covering breast cancer scars, and in those leaving difficult circumstances such as gangs, prisons, and domestic abuse. Ultimately, they "…can be indelible reminders of a significant life event" (Jablonski, 2013, p. 151).

Likewise, considerable speculation and examples about a connection to trauma exist in popular discourse. There are documented cases of facial scars being covered with flesh colored pigment and false beards tattooed onto men with facial burns rendering no hair growth (Post, 1968). Associated Press writer Stacey Plaisance (2006) published a story about Hurricane Katrina survivors who obtained tattoos. In her investigation, she interviewed several survivors. Their reasons for getting a tattoo included remembering, meaning, tribute, and the symbolism of putting the event behind them. Tattoos included location markers, storm symbols, crumbling bricks, the city skyline, and names. Tattoo artists in the area indicated that as many as half of all tattoos done during the previous year related to the storm (Plaisance, 2006). There are also accounts of individuals getting tattoos that match the numbers tattooed on relatives who survived the Nazi concentrations camps as a means for remembrance and connection (Rudoren, 2012). Further, accounts of trauma survivors add to the connection between trauma and tattooing. For example, Michelle Knight was abducted and held in captivity for more than a decade. She was subjected to beatings, starvation, and rape. After her escape, she publically talked about the tattoos she obtained connected to her experience. Among them included five roses representing each abortion she was forced to have, a dragon for protection, and one reading "my heart is not chained to my situation" (Jones, 2015). For her, tattoos represented remembrance and expression of what she was forced to endure, in addition to reclamation of her body.

Several other trauma-connected examples exist. A widespread practice of trauma survivors, along with their family and friends, is obtaining a semicolon tattoo. This symbol

represents that a story is not yet over and there is more to be written (Munz, 2015). Davies (2015) documented the act of including a deceased loved one's ashes in the ink used to do the memorial tattoo. A recent reality show provided clients with tattoos designed by artists in collaboration with a psychologist to help "…clients heal by serving as everyday reminders of how far they've come" (Meinert, 2015, para. 5). And finally, at least one counselor has recognized the role tattoos play for trauma survivors and offers meaning-making consultations prior to the client obtaining the tattoo (Shane, n. d.). The media describes numerous other examples and speculation about the role tattoos play in trauma (Ellingson, 2016; Newman, 2014; Phillips, n. d.; Schuster, 2015). Although more research is needed, memorial tattoos offer an entry point into the investigation of the link between tattoos and trauma.

Emotional Restoration: Memorial and Commemoration

Davidson's (2016) definition of a commemorative tattoo asserts "…they may be in memory or honor of a living or deceased person or animal; of a place, relationship, life event or transition; of something accomplished, worked at or for, still to be achieved, or yet to be dreamed" (p. 6). She created *The Tattoo Project* to catalog and study the meanings behind commemorative tattoos. She intends to "disrupt" the skewed associations of tattoos with negative human behavior and character (personal communication). This type of tattoo represents identity and relationship, both to self and with others (Atkinson, 2003). They also serve as reminders of the event (Gentry & Alderman, 2007) and may allow people to manage emotions, connect with others, and heal (Bates, 2009). However, Davidson (2016) pointed out the paucity of data available on memorial tattoos. Her search of Google Scholar for example, only returned 218 results, compared to 4,260 related to deviant behavior. While there are more conceptual pieces

regarding memorial tattoos available, my own academic database search returned few empirical studies. Most that did exist were in the form of student thesis or dissertation based research.

Anthropology researcher Acharya (2013) studied tattoos and storytelling. Nine participants responded to formal interviews and allegories were collected that resulted in three storytelling themes: 1) placement, 2) memorial, and 3) partnering. For these participants, memorial tattoos were the most prevalent. Six of the participants discussed remembrance, and reasons included keeping memories alive and sharing with others. When asked about getting a tattoo for remembrance, participants described their indestructible nature, the constant presence and connection, daily reminders, and the need to share their story as factors (Acharya, 2013). As such, they seemed to be reflective of individual life stories.

In an undergraduate thesis, Burden (2014) directly questioned the role of memorial tattoos. Participants in this study included 306 individuals ranging in age from 19-61. Of this sample, 56 (18.3%) reported having a memorial tattoo. Results of this descriptive, quantitative study indicated more favorable perceptions of memorial tattoos from others as compared to non-memorial tattoos, especially if the tattoo connected to grief and remembrance. The participants themselves considered memorial tattoos to be less disturbing, possess less stigma, and be more acceptable in work settings (Burden, 2014). They also considered those with memorial tattoos to be less likely to conform to prevailing deviant behavior stereotypes. This study provided a window into the social value and judgment associated with the practice of tattoo acquisition.

While associated with aspects such as expression and identity, the memorial tattoo most directly links to the experience of trauma through loss, grief, and remembrance. Gentry and Alderman (2007) surmised these tattoos serve to help express and cope with trauma experiences. It seems clear there is some therapeutic connection, that tattoos may in some way instill hope,

facilitate empowerment, or help to solidify and communicate our stories. Yet, there is a clear and wide gap in empirical data. More work is needed to fully understand this process and move beyond reliance on popular, anecdotal, and clinical accounts.

The connection with trauma experiences represents one of the sole areas of scholarship where tattoos are viewed fully positive in utility. Yet, scientific inquiry into tattoos and their connection to trauma is just beginning to emerge. And despite the available research, authors agree that our understanding of the psychology of tattoo acquisition and influence is limited, with one sided accounts and questionable conclusions, given various methodological issues and generally small sample sizes or focus on specific subgroups (Cebula & Kasten, 2015; Mun et al., 2012; Nathanson et al., 2006; Pajor et al., 2015; Roberts & Ryan, 2002). Tattoo acquisition was selected as a focus for this current research because of the gap in knowledge and focus on the heart of individual trauma survivor uniqueness and expression. Davidson (2016) suggested that commemorative tattoos serve memory functions by "…storing information, the meaning of which has been made by the bearer; preserving memory – protecting it from harm or decay; allowing retrieval at a glance, touch or thought; and inviting dialogue" (p. 9). Such processes directly reflect the work involved in stage two of Herman's (1997) recovery model and may serve to meet aspects of all three.

Summary

Psychological trauma is ubiquitous in our society and encountered by mental health practitioners in all settings. Trauma survivors often describe their experiences as unspeakable, and a natural tendency exists to bury such episodes, but this denial is rarely effective (Herman, 1997). Researchers estimated that over 90% of clients have experienced a traumatic event (National Council for Community Behavioral Health, 2013), thus it becomes imperative for

counselors to have a thorough understanding of trauma and its aftermath (Jones & Cureton, 2014). A variety of approaches are utilized with client survivors and it is often necessary to implement creative interventions given the difficulties sometimes encountered when putting horrific experiences into words (Marzillier, 2014). Clinical thinking on trauma has undergone significant changes in the past couple decades and continued research is needed to understand its etiology, development, and treatment (Jones & Cureton, 2014).

The link between tattoos and a potential amelioration of trauma also remains unclear. Sarnecki (2001) asserted that tattoos aid recovery "…by bearing witness to feelings too inchoate to express in words…their existence as a part of our body's landscape serves as a testimonial to survival" (p. 41). Gentry and Alderman (2007) argued that tattoos may represent an alternative means for expressing and processing events. More research is needed to understand the link between tattooing, their influence on meaning-making, the restorative role they may play, how they are connected to the recipient's identity, and their relationship to trauma coping and therapeutic interventions.

This chapter discussed a historical account of trauma development. A review of the literature relative to trauma survivor experience was provided followed by an examination of therapeutic interventions for survivors within the context of Herman's (1997) recovery model. Next, a review was provided for the body modification practice of tattooing including historical context and relevant research studies. The section concluded with evidence connecting the practice to trauma survivors. This study sought to begin filling a void in our knowledge base regarding this process and potential therapeutic aspects available for implementation during counseling interventions. The structure and procedure for the current study is presented in the next chapter.

Chapter Three: Methodology

The current project employed a qualitative methodology. This was a deliberate choice best suited to address the primary research focus, ascertaining the therapeutic benefit of obtaining a tattoo following trauma. The specific research questions were: 1) as an adult survivor of trauma, what is the lived experience of obtaining a tattoo and 2) how is tattoo acquisition beneficial relative to survivors' traumatic experiences? The case for the selected approach is made below.

Qualitative Research Design

Qualitative approaches in research of this type are appropriate, as the goal is to describe and understand the experience of the participants. Glesne (2011) noted that a "central purpose" (p. 7) of the interpretivist paradigm is understanding. Denzin (2010) further emphasized that investigations into social life are inherently interpretative. Thus, a focus on the meaning of human experience often calls for qualitative methods (Thomas & Pollio, 2002). Finlay (2011) noted, "qualitative research illuminates the less tangible meanings and intricacies of our social world" (p. 8).

A primary assumption of the interpretivist approach holds reality as socially constructed (Glesne, 2011). Such approaches also emphasize a situational context (Denzin & Lincoln, 1998). Since realities are constructed within a social context, it is assumed that "...assessing the perspectives of several members of the same social group about some phenomena can begin to say something about cultural patterns of thought and action for that group" (Glesne, 2011, p. 8). Essentially, one is searching for patterns or coherence across individuals. These patterns can help reveal information about phenomena under investigation.

Given the assumption that reality is constructed, qualitative approaches break with the positivist tradition of searching for truth and recognize multiple realities; individual perceptions and interpretations. Therefore, the goal of research is to capture the experience of participants while striving to limit preconceived ideas or understanding (Groenewald, 2004). Uncovering individual meaning necessitates going into the participants' natural settings, interacting with them, observing, interpreting, and reflecting (Creswell, 2012). Furthermore, qualitative methods approach insight through the emergence of information within a social context. Nelson and Poulin (1997) noted that these approaches allow researchers to recognize and be receptive to changes.

Relationship to Goals and Purpose of Study

The purpose of this study was to investigate the unexamined connection between tattoo acquisition and therapeutic benefits in survivors of trauma. While we know a good deal about the impact of trauma, less is known about coping mechanisms, especially in cases outside PTSD. Furthermore, while there is limited research on the role of expressive arts related to therapeutic intervention, very little exists regarding the role of tattoos even though there has been a strong connection made in popular media. Given the sociopolitical context of emotional trauma and individual differences relative to its consequences, the qualitative approach is ideally suited for investigating its impact. Additionally, the primary audience for this study is intended to be mental health professionals. A qualitative approach is appropriate because it is not always necessary for a counselor to demonstrate a cause/effect relationship, however, it is critical to understand clients and their experiences. The focus was not on explanation, but on description and understanding. In this case, such understanding provides clinicians with knowledge regarding the role tattoos play for trauma survivors who choose to obtain them.

This chapter outlines the foundations of the selected methodology. I provide an overview of the philosophy of phenomenology and how that translates into a research approach. I also provide my initial reflexive considerations, a process critical to this approach. Next, I examine how phenomenology has contributed to trauma inquiry and why it was the preferred method. Finally, within this context, I outline the procedures for the study including participant selection, data collection and analysis, steps to insure trustworthiness, and ethical considerations.

Phenomenology

Foundation and History

Phenomenology is grounded in the discipline of philosophy (van Manen, 2014). At its core, it is the study of essence (Merleau-Ponty, 1945/2014). Hatch (2002) noted, "phenomenological researchers seek to reveal the essence of human experience…" (p. 30). In Greek, the word phenomenology means "phenomena appear". Thus, phenomenological inquiry does not attempt to search for truth, or get into the minds of individuals; but strives to understand how things manifest or *appear* through our being in the world (Vagle, 2014). Finlay (2011) observed that phenomenology encourages us to focus intently on what is under investigation, to sit with the phenomenon, and uncover qualities relative to lived experience.

Husserl is generally regarded as the founding father of phenomenology (Reiners, 2012; van Manen, 2014). He was an Austrian-German philosopher who promoted ideas in opposition to positivist scientific inquiry. He placed emphasis on the lived world and ultimately the essence of experience (Finlay, 2011). One of his core concepts was *bracketing*, a practice intended to allow an individual to set aside "…all judgments about connections between experience and worldly events, thus freeing the mind to examine its own pure experience, independent of everyday biases" (Nelson & Poulin, 1997, p. 160). He believed this aspect of human

consciousness, as well as subjective experiences, to be of value for scientific investigations (Lopez & Willis, 2004). Heidegger, a student who broke with Husserl, emphasized the "sense of being in the world" (p. 160) as the source of understanding experience within a social context (Nelson & Poulin, 1997). The interpretation of these experiences is known as *hermeneutics*, a word derived from Hermes; a god in Greek religion and mythology who interpreted messages between gods (Thompson, 1990). In practice, it aims to make clear that which is normally hidden (Spielgelberg, 1976). Additionally, as our freedom is tied to situation contexts, choices we make also indicate meaning (Lopez & Willis, 2004). Merleau-Ponty viewed language and experience as inseparable and believed linguistic constructions lead to interpretations of experience. His ideas formed a method for inquiry based on the idea that science can describe and interpret, but never "arrive at pure truth" (Nelson & Poulin, 1997, p. 160). This suggests that perception is at the heart of understanding human experience (Thomas & Pollio, 2002). So, listening itself is revealing since our words are a transparent road to meaning (Ellis, 2014). In a real sense, phenomenology represents the intersection of science with art and the humanities (Finlay, 2009).

The Approach Relative to Research

Phenomenology as a research approach developed in opposition to methods grounded in the positivist tradition. Naturalistic researchers recognized that reality is not fixed and one must consider the individual; or subjectivity. Therefore, knowledge is obtained through interaction with participants under study (Reiners, 2012). Within this context, phenomenological approaches generally fall within two schools: descriptive/empirical or hermeneutic/interpretive (Lopez & Willis, 2004). Descriptive phenomenology is closely aligned with the thinking of Husserl and focuses on the description of essence related to phenomena. Hermeneutic phenomenology is aligned with Heidegger's views and strives to interpret lived experience (Finlay, 2011). Some

researchers view description and interpretation as part of a continuum, while others suggest diminishing the boundaries between the two altogether (Finlay, 2009). Other approaches include but are not limited to lifeworld, interpretive phenomenological analysis, first person accounts, reflective/relational, and existential (Finlay, 2011; Thomas & Pollio, 2002). This diversity can become problematic (Finlay, 2009). Therefore, Lopez and Willis (2004) urged making a clear distinction between these various philosophical nuances to ensure sound, valid methodology and findings. In practice, there is often overlap, however, mixing aspects of these and various other nuances of phenomenology should be considered carefully and conducted intentionally (Finlay, 2011).

Giorgi (1985) asserted that phenomenological research must focus on thorough description and capturing as closely as possible the original phenomena under investigation. To do this, he suggested four necessary steps including, 1) reading and re-reading of transcribed interviews, 2) searching written data for meaning units or expressions of the phenomenon, 3) describing psychological characteristics, and 4) synthesizing meanings. The idea is to thoroughly examine multiple accounts for commonalities and exceptions as the essence of the experience emerges (Nelson & Poulin, 1997). Giorgi (1997) later suggested that phenomenological research, regardless of variant, is descriptive, reductionist, and searches for the essences of meanings.

The philosophy of phenomenology is rooted in the suspension of suppositions (Reiners, 2012). Wertz (2005) noted, “phenomenology is a low-hovering, in-dwelling, meditative philosophy that glories in the concreteness of person-world relations and accords lived experience, with all its indeterminacy and ambiguity, primacy over the known” (p. 175). Therefore, the orientation of this approach places an emphasis on descriptions of human experiences, rather than cause and effect (Ellis, 2014).

This study was conducted within the framework of hermeneutic phenomenology. Given the nature of this work, there was an emphasis placed on contextual meaning and interpretation of participants' experience, congruent with the aim of hermeneutic approaches (Finlay, 2011). The motive was to move beyond simple description and discover meaning, thus "the meaning of phenomenological description as a method lies in interpretation" (Heidegger, 1962, p. 37). Therefore, it was necessary to get detailed accounts and encourage participants to explore their experiences. A focus was placed on participants' being in the world, rather than knowing it. Accurate communication of the meaning they placed on experience was sought rather than simple description (Reiners, 2012). And since we experience situated freedom as previously mentioned, how meaning influences our choices becomes an important consideration. Heidegger discussed what he considered the lifeworld, representing the notion that our reality is influenced by our place in the world. By accessing the narrative of research participants, experience is revealed (Lopez & Willis, 2004). Creswell (2012) suggested that this approach encourages the sharing of stories, empowers the participant, and allows people to hear their voice. In short, the methodology closely aligns with the beliefs of van Manen (2014) in that it was active, interpretive, and produced findings that reveal essence.

All forms of phenomenology recognize that subjectivity on the part of the researcher is inevitable (Finlay, 2009). However, unlike Husserlian and other descriptive methods, the goal of the interpretive form is not the absolute removal of personal knowledge prior to investigation as described by bracketing (Lopez & Willis, 2004). Rather, hermeneutic methods suggest that researcher knowledge is important or even necessary during inquiry and that researchers "…cannot remove themselves from the meanings extracted from the text" (Reiners, 2012, para. 12). Thomas and Pollio (2002) also noted that understanding can only take place when the life

experiences of both the participant and researcher are considered. The researcher is embedded in the process of inquiry and seeks to employ a phenomenological attitude characterized by openness, a posture described as "…disciplined naïveté, bridled dwelling, disinterested attentiveness, and/or the process of retaining an empathic wonderment in the face of the world" (Finlay, 2009, p. 12). Given this relationship, acknowledgment of researcher position is discussed next.

Positionality and Role of the Researcher

As already noted, bias is readily acknowledged in qualitative research. Hatch (2002) pointed out the difficulty of being fully objective in our work. Therefore, qualitative researchers emphasize having an awareness of attitudes, feelings, and assumptions in addition to the impact they may have on what is being investigated (Hatch, 2002; Moustakas, 1994). By understanding preexisting beliefs, examination and questioning of new evidence becomes possible (Finlay, 2009). Given the role of subjectivity in phenomenological research, this self-awareness is a critical first step of inquiry. As the process moves forward, this awareness will separate "…out what belongs to the researcher rather than the researched" (Finlay, 2009, p. 12).

One way of doing this is by considering positionality, or my place in space (Creswell, 2012). I must recognize how my background shapes my interpretation of the world around me, how I interpret meaning others attribute to their worlds, and the interaction of the two (Creswell, 2012). For example, I am a white, male, doctoral student in a position of privilege. How might these positions impact the research in this case? By answering this question, and considering preunderstandings relative to my topic, there is a clear acknowledgement of my central role within the inquiry process and a recognition that I am a part of and influence knowledge construction (Finlay, 2011).

Researcher Interest

Before conducting qualitative research, it is critical to become aware of personal biases and assumptions (Thomas & Pollio, 2002) regarding the targeted phenomenon. To help aid this process, I completed a bracketing interview conducted by an experienced phenomenological researcher. This activity served to model the phenomenological interview process and allowed me to discuss my own assumptions surrounding trauma, tattoos, and the possible connections between them. I analyzed the interview for themes and received feedback from the interviewer. The interview revealed that I maintain several assumptions about the connection between tattoos and trauma, such as, 1) tattoos are part of the meaning-making process, 2) thought goes into their design and selection, and 3) tattoos help their bearer communicate stories and identities. Interestingly, I realized even with these strong assumptions, that I do not have trauma related tattoos of my own. I am making connections based on my own beliefs about the general qualities of tattoos and how they may function under these circumstances. The remainder of this section was developed, in part, from reflection on this interview.

While trauma is a primary research interest, tattoo acquisition was the focus of this study. People with tattoos risk being perceived as inferior (Sanders, 1988). Additionally, Kjeldgaard and Bengtsson (2005) observed that previous research positioned tattoo acquisition as a devalued or even deviant practice, as highlighted in Chapter Two. In many ways, people with tattoos have been marginalized due to the historical social and research position regarding the practice, limiting our understanding of the phenomena. While this gap is of professional interest to me, I also have a personal connection to the topic.

I grew up in a conservative, religious environment. The act of obtaining a tattoo was generally viewed with skepticism or even judgment. I think this value echoed the general cultural

sentiment during that time as well. Like many practices, tattooing has a history of calling up specific images and stereotypes. The one exception in my environment seemed to be my father. He had a large Marine-themed tattoo on his forearm from his time in the military. No one ever talked about it or acknowledged how it conflicted with their values. I think the feelings associated with military service likely superseded any negative reaction to body art. I never asked about it either but remember thinking it was interesting.

I attended high school during the late 1980's at the height of MTV's cultural emergence, music videos, and *hair metal*. Something I noticed during this period were the musicians who proudly displayed their body art. In most cases, they exhibited much more than a simple tattoo; it was as though they were using their bodies as a canvas. These reference points expanded my thinking on tattoos and I began to view them as a symbol for individuality, personal statement, and rebellion.

Even though I appreciated the artistic merit in much of the work I saw, I was still hesitant about getting my own. Those early introjected values and admonishments still played a role. But my personality was a large factor as well. I am an introvert and focus more on my inner world, thoughts, and ideas. Tattoos seemed to be something more visual that projected a message outwardly to others; something more extraverted. I was also conscious of my appearance and the inevitable judgments others make about various personal characteristics. However, meeting my partner furthered my interest as she had a couple tattoos of her own. Like many, I took a lot of time considering aesthetic qualities, placement, and meaning. Finally, at the age of thirty I acquired my first one. The design consisted of Japanese kanji, a writing system adopted from the Chinese language (Hadamitzky & Spahn, 2012), representing faith/trust. I later surrounded this

by an enso (circle), which traditionally possesses several meanings including strength and freedom of mind.

Like so many other areas of life, my perspectives on tattoos have evolved far beyond those early values and considerations. I believe they are artistic and represent some unique purpose for most who obtain them. My tattoos hold significant meaning; a sentiment I hear from many others. In a sense, they establish a permanence of deeply held beliefs, interests, and experiences. Their connection to personal identity is primary and undeniable.

I recently read an account about hurricane survivors who obtained tattoos to help them manage and memorialize the experience. I believe people are motivated to get tattoos for many reasons and have a particular interest in the possible connection between their acquisition and past trauma experiences. This study is both a realization of that interest and a response to the recognition of the limited understanding we have regarding the expanded utility of this practice, particularly for those who obtain tattoos based on their trauma within a therapeutic context.

Epistemological Assumptions

Another way to extract supposition is by examining epistemological or ontological positions. I reflected on my epistemological assumptions relative to my work as a researcher and practitioner and how that may influence interpretation of data. As a counselor, I believe a client's worldview is paramount to understanding, expressing empathy, and ultimately to being an effective clinician. Regardless of what I believe, I must be able to empathize with, recognize, and utilize the perspectives of the client. Thus, I value multiple perspectives as primary factors in understanding the human condition.

I believe our environment, culture, and background influence who we are and how we experience things that occur around us. Therefore, by working with people in a particular

environment, we may come to understand their experience of that environment. This stance is constructivist in nature because I am more concerned about understanding the perception of people I am working with rather than uncovering some universal *truth*. My position must be characterized as interpretivist. Life is composed of ill-defined problems, or problems without clear answers. My approach takes this state into account. It assumes things are not nice and tidy, nor do easily obtainable answers exist. Additionally, it recognizes the complexity and ambiguity that accompanies the process of inquiry. In summary, this approach means for me that "...absolute reality is unknowable..." (Hatch, 2002, p. 15) and places primary importance on multiple perspectives as a means for understanding the people and environments I engage in research.

As a researcher, I am interested in trauma and the impact that extreme events and circumstances have on the lives of the people who live through them. An early focus on resilience and the notion of psychological hardiness helped develop this interest area. Frankl (1963) heavily influenced my orientation, as he believed meaning-making is one of the most important aspects of life. He emphasized the role we play in determining how we react to events that happen to us (Frankl, 1963). I value and believe each of us maintains agency and self-determination relative to the course of our lives.

As a reflexive practitioner, I am acutely aware that I carry preconceived notions, values and beliefs into every situation. My position here is congruent with those who point out the difficulty of being fully objective in our pursuits (Hatch, 2002). Qualitative researchers emphasize having an awareness of attitudes, feelings and assumptions in addition to the impact such factors have on what is being investigated (Hatch, 2002; Merriam, 2009; Moustakas, 1994). I work hard to remain mindful of my emotions and reactions for the duration of my work and use

them to illuminate new possibilities and directions. They also uncover potential blind spots and prejudices.

Phenomenological Based Trauma Inquiry

Some suggest that phenomenology holds promise for advancing our knowledge of the trauma experience, especially relative to time, memory, and individual differences (Larrabee, 1995). Yet, relatively few phenomenological-based trauma investigations exist (Gusich, 2012). The few recent examples available in the literature are briefly highlighted next, lending support to the selected methodology for this study.

The research on trauma from a phenomenological perspective varies in focus and population. Yarrow and Churchill (2009) explored experiences related to work with male survivors of sexual trauma. Using interpretive phenomenological analysis, they identified six categories relative to therapeutic needs. Nia, Ebadi, Lehto, and Peyrovi (2015) examined the experience of death anxiety in veterans of the Iran-Iraq war. The research utilized Husserl's phenomenological method and produced data that helped explain the development of cognitions and fears. Focusing on a different aspect of trauma, Preble (2015) explored how trust is created within the context of support services for former workers of the sex industry. Methods followed the phenomenological recommendations of Moustakas and revealed themes associated with a history of betrayal and learning to trust. In a study of individuals with psychosis, Mapplebeck, Joseph, and Sabin-Farrell (2015) used interpretive phenomenological analysis to examine post-traumatic growth. One key theme was identified as "the adapting self" (p. 38). Other themes related to post-traumatic growth included finding meaning and purpose, support, inner strength, and awareness. Finally, Johnson, Taggart and Gullick (2016) investigated the lived experience of burn survivors in Australia, using Heidegger's hermeneutic framework. Several themes emerged

for survivors' family members including: challenging physical otherness, rethinking work, focusing on self-care, and looking for the return of "good days". Clearly, the phenomenological research on trauma is varied and fragmented.

These studies demonstrate the utility of various phenomenology methods in understanding experience across a broad range of trauma types. Nelson and Poulin (1997) recognized that positivist approaches do not fully meet the needs for knowledge in counseling and other therapeutic environments. Giorgi (1985) further concluded that phenomenology is well-suited for counseling-related investigations due to the emphasis placed on understanding and meaning. Moreover, the hermeneutic approach is called for when the researcher seeks meaning and interpretation of a practice (Reiners, 2012). Svedlund, Danielson, and Norberg (1994) also suggested that the interpretive approach is useful for understanding context in studies related to practice, in this case, counseling. I wanted more than simple descriptions about participants' tattoo practices related to their trauma experiences. I wanted to understand the meaning they assigned to the practice; their perceptions and interpretations. Ellis (2014) argued for a phenomenologically based exploration of trauma as "…narratives of trauma are always contextual, and they are infinite, dynamic, shifting and unique" (p. 326). Furthermore, van Manen (1990) suggested that interpretation should more strongly be considered when a project involves aspects related to expression. Johnson et al. (2016) suggested the interpretive approach is useful with trauma survivors as Heidegger discussed the importance of temporality. Temporality refers to a relationship with time, so one's state of being before and after some occurrence may be determined. This supports the current study as time is of relevance in the context of trauma recovery. Finally, examining the role of tattoos supports the use of phenomenology as Gentry and Alderman (2007) asserted, "…a fuller understanding of the

symbolism and meaning behind any tattoo can be learned through the personal stories that accompany it" (p. 189). With this foundation in place, attention turns next to study procedures.

Method

To insure ethical considerations were present, the initial steps for this study included presenting the project for review and approval from the University of Tennessee's Institutional Review Board (IRB). Aspects of the approved study included participant selection process, informed consent, interview protocol, valid procedure, and trustworthiness. Each are described below.

Participants

Thomas and Pollio (2002) suggested that the two most important criteria in selecting a sample for such a study include individuals, 1) who have experienced the phenomenon in question and 2) are willing to discuss it. As such, sampling in this study was purposive to target participants with a direct connection to the research questions. Snowball sampling through word-of-mouth was also anticipated and encouraged to occur through this process as well. Vagle (2014) noted that sample size in a qualitative research project depends on the research question and the complexity of the phenomena under investigation. Other researchers suggested at least five, allowing for the collection of multiple in depth interviews (Creswell, 2013). With those guidelines in mind, I sought 6-10 participants. These participants were solicited from a mid-sized Southeastern city. I posted information in the community (tattoo shops, public bulletin boards, etc.) and utilized tattoo shop owners, the primary gatekeepers of this community, to help identify potential candidates. Shop owners posted IRB approved fliers (Appendix A) and offered them to clients who fit the inclusion criteria. They shared the information flier along with my contact information so potential participants could follow-up with me if they were interested.

No information was given directly to me by shop owners or artists. It was up to individuals to contact me regarding participation.

Inclusion criteria included those who, 1) experienced an event they deemed traumatic, 2) obtained a tattoo related to that experience, 3) were over 18 years of age, and 4) were at least twelve months past the trauma event. This last point aimed to ensure participants were beyond the immediate concerns following their experience and had begun the process of stabilization. Given the complexity of trauma, and the interaction of personal factors, the period required for a sense of safety can vary widely. In cases of complex trauma, the process may take months or years. However, in other types, stabilization may be achieved in days or weeks (Manitoba Trauma Information & Education Centre, 2013). Participation was not restricted regarding other variables. Each participant received compensation in the form of a $15 Visa gift card as an incentive.

A total of nine individuals meeting the study's inclusion criteria were initially screened. Three individuals, including two males, decided not to participate prior to interviewing. Six females ranging in age from 20-48 comprised the study sample and completed interviews. None of the confirmed participants chose to withdraw from the study once started.

Informed Consent

Participants had the opportunity to learn about the purpose of the study, ask questions, and consider whether they wanted to participate. I first described the study to them (in person or via a phone call) and discussed any questions or concerns. Potential participants contacted me with their decision after taking time for consideration. In the event of low literacy, the available written information about the study would have been supplemented by non-written, in-person communication to insure accurate transmission, understanding, and clarification. This was not

necessary. Time was taken to ensure that all participants fully understood the research purpose and procedures. Formal informed consent, as approved by the IRB (Appendix B), was discussed with each participant prior to the start of the interview and included information regarding study process, involvement, rights of participants, ability to withdraw, confidentiality, compensation, and potential benefits and/or risks of participation. A clear understanding between researcher and each participant was reached.

Phenomenological Interview Protocol

Interviews for this study were open-ended and intentionally broad to avoid participants being led by researcher assumptions (Creswell, 2012). van Manen (2014) noted that multiple, in-depth interviews allow for meaning construction. Each participant was interviewed once. Moustakas (1994) recommended beginning with two overarching questions based on the context of the study. The opening question should be constructed in a way to allow for wide, descriptive responses from the participants (Thomas & Pollio, 2002). In this case, participants were prompted with, 1) "tell me about your trauma experience", 2) "tell me about obtaining your tattoo(s)", and 3) "tell me about the ways in which those two things are connected". While not always necessary in phenomenological research, an IRB requested and approved interview protocol (Appendix C) was developed to provide a basic structure for each interview. Therefore, the interviews provided the means for answering the research questions of the study, 1) as an adult survivor of trauma, what is the lived experience of obtaining a tattoo and 2) how is tattoo acquisition beneficial relative to survivors' traumatic experiences?

Interview sessions averaged 60-minutes in length and took place in office or other private settings convenient for participants. These included the participants' homes, public libraries, and local hospital meeting spaces. Sessions were recorded using a digital voice recorder and securely

stored. Interviews were open-ended, beginning with the three broad prompts above and progressing with the opportunity for follow-up questions as appropriate and based on participant response elaborations. Examples of this included, “tell me more about that” or “please provide an example”. While gaining specific information with this type of interview is generally more difficult (Sands, 2002), it allows for a more naturalistic process and one in which participants play an important directive role (Glesne, 2011). Any nonverbal responses such as gestures and facial expressions were recorded as part of my field notes. Finally, participants were encouraged to share any further thoughts after the conclusion of the interview. Following data analysis, I shared results with participants via email for further clarification and confirmation as recommended by qualitative researchers (Glense, 2011). In summary, the interview process involved obtaining rich descriptions from participants while clarifying and interpreting where participants took me during the process.

Self-Reflexive Process. The approach to fieldwork in qualitative research begins with a stance of being open to all possibilities (Merriam, 2009). Methods may include observations, participants’ own journal writing, or reflective writing. Maintaining a reflective journal was an important aspect of this study (Appendix D). Engaging in this process as I conducted interviews allowed me to determine how my experiences impact me as a researcher, and ultimately the work I do (Sands, 2002). This activity was beneficial in terms of recognizing and managing the personal assumptions, beliefs, biases, and attitudes that may impact observation and analysis (Goodall, 2000). It also provided a means for processing my own emotional responses during the study (Ellis, 2014). Additionally, the bracketing interview helped to identify assumptions and beliefs of which I needed to remain mindful (van Manen, 2014), to limit interference with

discovery of new information from my participants. These processes help lend confidence to the findings.

Data Analysis

Prior to analysis, interviews were transcribed in a complete manner inclusive of colloquial words and other verbal sounds. Spelling and grammatical errors in the interview and journal data were corrected. Real names and places were replaced with pseudonyms selected by participants to protect their identities. Researcher notes including physical expressions, verbal emphasis, and other observations were indicated in the transcripts. Transcription and analysis began immediately following the start of interviewing in order to identify when saturation occurred. Because of my chosen approach, I expected findings to be complex and ambiguous (Finlay, 2011). The analytic process featured an interpretivist and inductive quality. A priori categories concluded with themes (Reiners, 2012). In hermeneutic phenomenology, "…interview transcripts are read and reread, and common concepts compared within and across transcripts until a defining theme or 'essence' of the phenomenon emerges" (Johnson et al., 2016). The commonalities that emerged serve to elucidate the shared essence (Creswell, 2012; van Manen, 2014). Analysis, therefore, was not focused on explanation, but on describing and understanding the experience of the participants. Comparison across participant stories allowed for the emergence of meaning.

Coding. The narratives generated during the phenomenological interviews imply and communicate participant experiences and thus serve as the text for interpretive analysis (Lopez & Willis, 2004). Data analysis in the phenomenological approach involves identifying and coding themes while trying to find common elements that participants have experienced. I followed Saldaña's (2013) recommendations for coding data. He described a code as "…a word

or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute" (p. 3). Coding involved reading the data line by line searching for patterns significant to understanding the experience of my participants. Meaning units, or words and phrases connected to the constructs of the study, were identified and noted in text. Coded data was then developed into themes and categories as the psychological quality of the phenomenon was understood. Review of these themes began to reveal meaning behind the behavior and activities taking place by my participants. A thematic structure was developed by noting collective themes across participants, unique themes for individuals, descriptive stories of how the themes relate to one another, other primary patterns, and the meaning participants derive from their collective experience (Saldaña, 2013). Finally, based on this thematic structure, a descriptive narrative was developed (van Manen, 2014).

Hermeneutic Circle. A single reading of transcripts may be insufficient to capture the essence of the phenomenon (Nelson & Poulin, 1997; Saldaña, 2013). This search for essence is further confounded due to socio-historical contexts of the participants as well as differences of linguistic understanding between the participant and researcher (Thomas & Pollio, 2002). As such, Reiners (2012) noted that interpretive phenomenology "…utilizes the hermeneutic circle method of analysis, where there is continual review and analysis between the parts and the whole of the text" (para. 12). This involved continual reading, reflective writing, and interpretation (Kafle, 2011). The overall process of meaning searching concluded with a synthesis of meaning from all participants into general statements about the essence of their experience (Nelson & Poulin, 1997).

In sum, and as informed by the above, data analysis involved numerous steps. These included, 1) transcription of the interviews, 2) an initial read through to compare text against the

audio recordings, 3) insertion of non-verbal gestures and other field notes into the text, 4) additional transcript readings, 5) initial researcher descriptive and in vivo coding (Appendix E), 6) a secondary cycle of affective coding, 7) phenomenological interpretation of themes, 8) building of a thematic structure (Figure 1), 9) member checking, and 10) elucidation of the essence revealed through interaction with participants and the thematic structure. This process was consistent with rigorous hermeneutic processing, and the methods described by Saldaña (2013) for capturing the essence of the data.

Establishing Rigor and Trustworthiness

In qualitative work, trustworthiness of the data is the important consideration, in contrast to validity and reliability present in more traditional, positivist forms of research. (T. Paulus, personal communication, 2012). Lincoln and Guba (1985) advanced this expectation when they asked, "how can an inquirer persuade his or her audiences that the research findings of an inquiry are worth paying attention to?" (p. 290). This is an important foundation to establish as results must be deemed credible to advance meaningful and useful discourse around the topic under investigation.

As a post-modern researcher, I accept there are multiple ways of knowing. However, this position may create a dilemma within the research context when considering the need to ensure credibility for the larger scientific community. Tracy (2010) acknowledged that qualitative methods are ever evolving and require regular dialogue regarding the assurance of quality. She developed eight overarching criteria for quality qualitative research including topic worthiness, rich rigor, sincerity, credibility, resonance, significant contribution, ethics, and meaningful coherence. I selected this framework to guide the credibility of the current study and each criterion is met as follows.

Figure 1. *Building the Thematic Structure*

First, Tracy (2010) asserted that topic worthiness means, "good qualitative research is relevant, timely, significant, interesting, or evocative" (p. 840). This study represents one of the first inquiries of its kind. Knowledge gleaned has the potential to shed light on practices that address and help alleviate human suffering. It investigated an intrinsically interesting, little-known phenomenon. Second, resonance is the ability of research to meaningfully impact others and promote empathy and identification, even if the reader has no direct experience with the topic (Tracy, 2010). While this type of research may be limited in the ability to generalize findings, I do believe it has the potential to have such impact. Virtually everyone has been directly or indirectly impacted by psychological trauma. The findings of this study have the potential to illuminate processes that address survivor recovery and should be of interest to those in the mental health community, especially those engaged in trauma work. Third, sincerity is present as I communicated my positionality and epistemological assumptions. This was done prior to beginning the study and reflection continued throughout. Fourth, quality research should also contribute to our knowledge of a topic, improve practice, generate additional research, and/or empower (Tracy, 2010). This research provides new insight on the relationship between trauma and the acquisition of tattoos, leading to new insights into therapeutic aspects of trauma recovery.

Fifth, rigor also contributes to high quality research, which speaks to the need for careful consideration of methodology (Tracy, 2010). As discussed above, interpretive phenomenology was intentionally selected given the goals and questions of the current research proposed. Additionally, the methods used to include selection of participants, number of interviews obtained, analysis of the data, application of theory, and ultimately interpretation were completed with care and in accordance with recommendations relative to interpretive phenomenology and

qualitative research. To ensure a quality research product, I began participating in an interdisciplinary phenomenology research group at the University of Tennessee, Knoxville founded by Dr. Howard Pollio and currently led by Dr. Sandra Thomas, well know phenomenology scholars. This group meets weekly and provides researchers feedback regarding their methods and considerations for various stages of projects. I began orienting myself with the group early in the dissertation process and took samples of completed interview transcripts and data analysis for real time feedback and discussion. Work with this group helped to process and confirm findings, in addition to expanding "…awareness beyond immersion in the data itself" (S. Thomas, personal communication, 2017). I also participated in the bracketing interview discussed earlier prior to conducting my own interviews as an additional measure of rigor. These processes contributed support to quality phenomenological practice.

Sixth, I demonstrated meaningful coherence by the care taken to intentionally select a suitable theoretical framework and methodology following an extensive review of the literature. Findings are connected back into what we know and suggestions about future research are discussed in light of that understanding. Seventh, credibility involves the trustworthiness and plausibility of research findings (Tracy, 2010). I believe several markers related to both quality phenomenological and qualitative support this criterion. For example, the use of a theoretical model may be used to help guide the research in hermeneutic phenomenology and make decisions during inquiry (Lopez & Willis, 2004). In this case, I utilized Herman's recovery model. The framework helped with interpretation of findings in a deliberate and purposeful way. Heidegger believed that a researcher's depth of involvement during phenomenological inquiry serves to establish credibility (Reiners, 2012). Therefore, I continually assessed the length of time needed to collect the necessary quantity and quality of data.

Hatch (2002) described another important feature of phenomenological research as bracketing. Bracketing or epoché refers to being aware of thoughts, feelings, attitudes, and assumptions while being able to limit their impact on what is being studied (Hatch, 2002; Merriam, 2009; Moustakas, 1994). Additionally, I conducted member checking once initial data analysis is complete. According to Glesne (2011), member checking is a method that can be used to help verify data trustworthiness by working with participants in a way that essentially allows them to help confirm findings. Some suggest this step is not necessary in interpretive phenomenology (Reiners, 2012). However, I feel this process is consistent with my chosen design and forms yet another layer of interaction that confirmed and strengthened interpretation of my findings. I also feel this process conveyed respect for participants while lending additional confidence to data analysis. I took my writing, thoughts, and developed themes back to participants to solicit their feedback.

Using guidelines such as these were helpful to ensuring a quality research project. While there are many examples of such a process, I believe Tracy's (2010) points resonated with both the goals of this research project and the chosen methodology. By employing these systematic practices, it is hoped readers are assured of the trustworthiness of the final product and meaningfulness of the findings.

Ethical Considerations & Participant Safeguarding

Lastly, Tracy (2010) promoted ethics as the end goal of quality research. Denzin (2010) further emphasized that qualitative research supports the human dignity of participants and we must remain accountable for our actions. Therefore, efforts were taken to ensure an ethical process during the study along will protection of participants. All research is biased. The interests we hold, the things we choose to study, and the way we choose to study them are all

based in our beliefs and values. Conclusions are based in part on our worldviews. While qualitative research focuses on the worldviews of others, we must always remain mindful of the ways we may unintentionally influence investigations. Creswell (2012) cautioned researchers to understand this impact. Therefore, we must always question our own work.

The ACA Code of Ethics (2014) mandates several other ethical considerations relative to conducting research. Foremost, is the effort to respect study participants and avoid physical or psychological harm, discussed below. Additional aspects include confidentiality, transparency, accuracy, handling of errors, and use of the data. This study was conducted in accordance with all ACA ethical guidelines. Additionally, the purpose of this research aimed to support the ethical charge to promote knowledge beneficial to my population, trauma survivors (Newman, Risch, & Kassam-Adams, 2006).

Finally, this study focused on the traumatic experience of participants. A primary concern was potential distress relative to re-traumatization. No clear standards for avoiding such episodes are established, however, some guidance is provided in the literature. While a minority of trauma survivors experience distress during research studies, most report the experience to be positive, and many express gratitude for the opportunity to tell their story (Newman & Kaloupek, 2004; Seedat, Pienaar, Willams, & Stein, 2004). One participant of this study offered such a sentiment during member checking. Further, other research suggested no deleterious effects for trauma survivors participating in investigations (Griffin, Resick, Waldrop, & Mechanic, 2003). Draucker, Martsolf, and Poole (2009) advised screening potential participants for signs of distress prior to interviewing, and monitoring for distress during the study. They recommended using direct questions to assess stress level, suicidal ideation, and thoughts of harm to others. For example, if a participant was observed becoming physically distressed (i.e., tears in eyes) during

an interview, I used check-in questions such as “are you ok” or “do we need to stop” to allow for the opportunity to pause, address the discomfort, and determine if it was appropriate to continue. Such caution was implemented during two of the interviews, however participants wanted to continue. While I cannot ethically engage in counseling during my research tasks, I still have a clear obligation for participant safety. The risk of distress, in the form of feelings and emotions, was discussed during the informed consent process. Options to address such distress were provided to all participants including a list of local mental health services providers if referral became necessary. Additionally, the researcher has experience with trauma and worked to insure sensitivity during the interview process while monitoring for signs of distress.

Summary

This chapter outlined the purpose of qualitative research and the foundation of phenomenological philosophy and related research approaches. The case was made for the selection of the hermeneutic method for the current study as the desire was to capture the essence of participant experiences with trauma and tattoo acquisition through the interpretation of rich narratives gathered during the interview process. Researcher positionality was explored and a deliberate process for ensuring rigor and trustworthiness of the data was provided. Finally, study procedures were outlined with attention paid to established phenomenological practices.

Chapter Four: Findings

The purpose of this study was to understand the experience of trauma survivors who acquired a tattoo in connection with their trauma event(s). This project was conducted within the context of two overarching research questions, 1) As an adult survivor of trauma, what is the lived experience of obtaining a tattoo and 2) How is tattoo acquisition beneficial relative to survivors' traumatic experiences? Participant characteristics, experience, and findings are discussed in this chapter.

Fusch and Ness (2015) noted the importance of saturation for studies of this kind. While lacking standardization, one indication is reaching a point where there is no new data. They noted that smaller studies can meet this standard more quickly. I analyzed and coded interviews as they were completed, and noticed no new meaning units appearing once I reached the fifth and sixth interviews. Data saturation was achieved. Additionally, the themes were consistent across all the participants.

One of the hallmark methods for gathering data in qualitative research is the interview (Hatch, 2002). This is true of phenomenological approaches as well. An emphasis was placed on the creation of in-depth narratives that served as the basis for data analysis and the means for uncovering the meaning behind participant experiences (Moustakas, 1994; Lopez & Willis, 2004; Vagle, 2014). The interviews served as a way for participants to communicate their stories, answer research questions, and provide insight regarding experiences (Josselson, 2013). The tone of these interviews reflected shock, suffering, struggle, resolve, and acceptance. I was struck by participant candor and the intensity that often characterized the interview process.

Interviewing is especially important to hermeneutic phenomenology in that it establishes the written record to be analyzed (Lopez & Willis, 2004). Vagle (2014) advised that constructing

meaning *for* the participants or leading must be avoided; rather, questions should allow information to *appear from* the participants. As described in the previous chapter, care was taken to ensure participants were not influenced by researcher assumptions during the interview process. Follow-up questions were asked in a manner to encourage and elicit further depth of concepts introduced by the participants. This was intentional to be congruent with the phenomenological assertion, "…the flow of dialogue is set by the participant" (Thomas & Pollio, 2002, p. 26). Member checking contributed to the confidence of the information derived from the interviews. A list of the identified themes with brief descriptions were sent to all participants. Every participant responded and confirmed that the information was accurate relative to their experience. I believe this high response rate was indicative of participants who were engaged in the inquiry process and eager to tell their stories. They were able to continue their processing of experiences in a safe forum.

Analysis of this dialogue went beyond simple description of experiences. Hermeneutic phenomenology calls for interpreting the nature of lived experience (Finlay, 2011). Conversations with the participants, observations related to these interactions and their behavior, the hermeneutic circle informed process of continually pouring over the narrative produced text, my reflective process during the study, and member checking my work all contributed to the process of building an interpretive, thematic representation of participant lived experience related to the research questions. Each participant communicated a unique experience. However, several elements and themes common to their experiences appeared and are detailed in this chapter. As discussed earlier, pseudonyms are used to protect confidentiality.

Participant Descriptive Summaries

To establish context, it is necessary to review individual participant information. Basic demographic information is presented in Table 1, followed by brief summaries of each participant. This information begins to establish the events that led to tattoo acquisition and build to the themes identified in the following thematic description section.

Participant 1: Kay. Kay described ongoing and compounded trauma episodes. She experienced her first miscarriage eight years ago. Having been told she was unable to get pregnant, this first episode was unexpected and shocking. She conveyed a sense of terror and discussed the fear she experienced because of the blood loss, something she had never seen before in real life and ascertained at the time to be life threatening. When she realized she was pregnant, there was a rush of happiness that was quickly abated with confirmation from the doctor about what was happening. Kay and her partner would go on to experience five more confirmed miscarriages. These experiences resulted in a sense of not being able to sustain life, "…it was like life was coming out of me. You know, just my life was ebbing away because I couldn't give life to what I was supposed to." She described her partner as very supportive; her "rock". However, she is a private person and survived these experiences in the absence of acknowledgement or support from her parents and mixed efforts to provide comfort received from others. She felt like a disappointment, and thought of herself as defective, "…like buying a toy that's already broken." Overall the trauma of her losses resulted in feelings of uncertainty, loneliness, abandonment, detachment, fear, brokenness, and guilt. She obtained a tattoo of a miscarriage support ribbon with angel wings, placed on her wrist, to represent her lost children while keeping them close to her. She is also planning another tattoo to represent, putting behind her, all the struggles she has overcome because of these experiences.

Table 1. *Outline of Participant Descriptions*

Participant	Demographic Data	Age	Trauma Type
1	Caucasian, Female	40	Complex, personal violation (rape) and personal loss (miscarriage), multiple episodes
2	Caucasian, Female	28	Complex, emotional and physical abuse, multiple episodes
3	Caucasian, Female	48	Personal loss (child), single episode
4	Caucasian, Female	20	Complex, authoritarian father and suicidal friend, experienced over many years
5	Caucasian, Female	25	Complex, personal violation (rape), suicide attempt, single episodes
6	Caucasian, Female	31	Complex, personal violation (sexual assault and rape) and suicidal partner, multiple episodes

Participant 2: Emily. Emily suffered her trauma at the hands of her partner. Following a military deployment, he started abusing alcohol and became physically and emotionally abusive. The abuse increased over the next couple years and included pervasive hitting, shouting, emotional outbursts, explosive volatility, shaming, and name calling ending in an episode involving several gunshots being fired in her direction during a moment of rage. There was a sense of being trapped that was compounded by a lack of finances and the presentation of other obstacles that diminished her ability to remove herself from the situation. For example, she perceived judgment from her mother that extended from religious belief. She experienced frustration afterwards because she did not view herself as a victim, while others seemingly tried to promote a victim status. She knew she had to get out of the situation and ultimately sought divorce, but also viewed herself as a survivor and strove for a sense of normalcy. Her partner harassed her periodically for several years following the divorce which is being held in check by a restraining order. Emily only realized the toll these experiences had taken on her once she started to date again. She described the process as "emotionally difficult … significantly more difficult than it had been before." She felt broken. Her trauma resulted in issues such as lack of trust in others, avoidance, hypervigilance, emotional triggers, quickly bursting into tears, and retreating into quiet submission during perceived threats. She found traditional avenues of coping ineffective. Religious explanations and suggestions did not connect with her experience. Her early attempts with therapy were similarly unsatisfying. Her decision to get a tattoo on her back was a means for reclaiming her body and her independence.

Participant 3: Jamie. Jamie's traumatic event occurred nearly two decades ago and involved the loss of her child during childbirth and the related physical trauma to her body. She received a drug to induce labor unapproved by the FDA. During labor, it was discovered that her

uterus had ruptured and she was bleeding internally. They performed an emergency cesarean section but were too late to save the baby. An emergency hysterectomy also had to be performed to save her. During this event, Jamie was in and out of consciousness and has fuzzy memories of the procedures, medical staff discussing the condition of her baby, screaming in the room, and her arms being tied down. This episode resulted in a loss of direction and lost dreams. She experienced fear, emptiness, uncertainty, and loneliness for months as she physically recuperated. Emily also discussed the initial coping skills she engaged in and described as "unhealthy". These included increased substance use, overspending on random items, and promiscuity. She started therapy about three years following the incident. Over the course of several years, she began working through the grief and behaviors related to her loss. Ultimately, she realized her unhealthy relationships were a function of "…trying to save everyone else because I couldn't save my daughter." While she had never previously considered a tattoo, she wanted something to memorialize her child. She obtained a butterfly tattoo on her back as a symbol of the transition from life to death, a meaning she took from a movie reference.

Participant 4: Sophia. Sophia's traumas occurred over many years beginning in childhood. She had a very difficult relationship with her authoritarian father, one that she described as making her feel "small". She discussed episodes where she never felt as though she was good enough. This feeling of never measuring up was the result of feeling constantly beaten down emotionally by him. He acted differently in public than in private, something that compounded the situation because others did not see what it was like for her. He held "unusually high" expectations, lacked warmth, wouldn't listen, yelled, and demanded that everything be done just as he saw fit. She described the court mandated visitations following her parents' divorce as something she never wanted to do; a chore. This relationship became "taxing" and

ultimately, she found herself trying to "…please everybody else because she couldn't please him." Not only did this impact relationships, but certain aspirations were shattered as well because she simply did not feel she was capable. While in college, she lived through another traumatic experience related to the suicide attempt by a close friend. This was a very fearful time for her because initial details were unavailable and she had never been in such a situation, and was unsure about what to do when contact was finally established. The range of issues and emotions she experienced during these times included an inability to eat or sleep, fear, uncertainly, a sense of always being on the losing end, thinking that the source of problems was always her, self-blame, and isolation. Her experiences led to counseling where she learned how to negotiate these thoughts and feelings. She talked of her mother always saying, "this too shall pass" during episodes with her father. She had this phrase tattooed on her wrist following by a semi-colon. The semi-colon inclusion represented a reminder of her friend, and together, relay a sense of, "…everything is going to go on."

Participant 5: Kassandra. Kassandra's traumatic experience stemmed from a single episode. She discussed being at a party in a non-commercial location. She had been drinking heavily, was drugged by someone, and raped. The events are hazy and were described as vague recollections. She remembers being with a group of friends, going in and out of awareness, someone coming up to her, trying to leave and being unable to do so, and not being able to find the door. She recalled her full awareness coming back and finding herself in the middle of the dance floor, sobbing with her clothes undone and torn off. She filed a police report and let authorities perform evidence collection. However, the police did not follow through on her complaint because she was drunk, and the case was eventually closed. In the aftermath, she described not feeling like a person, along with pervasive disruption. She had a sense of who she

was and where she was going, but following the event it "…was just gone, like it was all erased, because I would never be that person again." She experienced several lasting consequences including fear, loneliness, unwanted *victim* responses from others, anxiety, hypervigilance, depression, and days of disrupted or no sleep. Behaviors changed such as the cessation of drinking alcohol. She also experienced a general detachment from life as she isolated herself for hours, withdrew from activities, and limited interactions with other people. She was diagnosed with PTSD and tried to pretend everything was okay. This avoidance ended with an attempted suicide. Kassandra reported that she tried counseling for a while but stopped going. She credits "forced" social interaction with peers at college and a supportive, understanding partner who "doesn't think less" of her as the positive factors that helped her move forward, though she still views her recovery as a work in progress. Her tattoo is a quote on her back, *I'm not what happened to me, I am what I become of it* that represents getting through the event and regaining control.

Participant 6: Sara. Sara's initial trauma experience resulted from having unintended sex with someone while she was drunk when she was nineteen. She described waking up during the act and did not initially view it as a "problem". This changed as others who heard about it told her she was raped. She described the event as "different" from previous sexual assaults she had experienced in terms of the "mental trauma". She also described a gradual process of understanding what had happened, akin to waking up. The event led to issues with her boyfriend at the time, a relationship she described as also being traumatic. He engaged in heavy drug use and led a generally unhealthy, dependent lifestyle. He engaged in emotional abuse, stalked her, blamed her for his problems, and attempted suicide. She tried to rationalize what had happened but descended into a "downward spiral" of emotions. She described negative coping strategies.

She engaged in multiple sexual encounters, later realizing the promiscuity was a misguided attempt at regaining some kind of control, because she viewed it as having a choice in terms of what she was doing. She stopped interacting with others and cut off anyone associated with her ex-boyfriend, "…I just completely withdrew inside myself." Sara experienced other consequences such as irritability, a lack of focus, and wildly shifting moods, "I couldn't function." After these episodes, she felt unsafe, "…completely shut down", and took a medical leave of absence from college. She moved back to a very rural community to live with her parents. While not a private person, she was withdrawn and did not attend to personal hygiene or diet. She was not reading, a favorite pastime. With time and the support of her parents, she started "coming out". She began to feel "normal" again and started to interact with others. However, she experienced a sense of caution when interacting with someone new, for fear of the unknown or a repeat of prior nightmares. She is more hesitant with men, doesn't like people touching her, and avoids depictions of unhealthy sex in the media, things that "…continue to this day." She still has triggers that impact her behavior, but also a supportive partner who understands. Her tattoo is a leaf representing change, designed by Sara herself and placed on her inner thigh.

Overall, the participants described a range of consequences stemming from their trauma experience consistent with those discussed in Chapter Two. These included lack of safety, depression, anxiety, hypervigilance, fear, shock, confusion, lack of trust, diagnosed PTSD, nightmares, detachment, and avoidance behaviors. Other characteristics described included the event being unexpected or sudden, a sense of being trapped, a lack of understanding and searching for *why*, a questioning of spirituality, unfairness, insecurity, disrupted or unrealistic thinking, sleep difficulties, self-blame, and triggers that usher in unwanted memories and

emotions related to the event(s). Most described an initial period of engagement in ineffective coping before finding more successful resolution strategies. Some participants also seemed to fit the pattern for complex trauma. For example, one participant experienced rape as an adolescent before the adult trauma that led to tattoo acquisition. Another witnessed an abusive and substance using parent as a child, before ending up in an emotionally and physically violent relationship later in life. Or the trauma event(s) took place over an extended period of time. Collectively, the aftermath of trauma as experienced by these survivors is consistent with the available literature. Individual participant descriptions are provided in the next section.

Thematic Description: Acquiring a Tattoo Following Trauma

Analysis of the data revealed patterns that cut across the experience of all participants. The primary themes that emerged through this work included, 1) *"it spoke to me",* 2) "*I want it to mean something"*, 3) *"I'm in control now"*, 4) *"it makes me happy"*, and 5) *"I've lived through it and I've overcome"*. The complete thematic structure developed from the analytic process discussed in Chapter Three is provided in Table 2. Each of these themes recurred across the data in several ways and I discuss them in detail next.

Theme 1: "It Spoke to Me"

As discussed in Chapter Two, people get tattoos for a variety of reasons. Some are drawn to artistic qualities, others to symbolism. Some will get one as a spur of the moment decision while others take time to process a plethora of considerations. Participants in this study all carefully detailed the process of getting a tattoo connected to their trauma. It became clear the act was an expressive one. Just as an artist might labor or deliberate over certain choices, so too did participants as it pertained to their tattoo acquisition.

Table 2. *Thematic Structure: Trauma Survivor Tattoo Acquisition*

Primary Themes				
"It Spoke to Me"	*"I Want It to Mean Something"*	*"I'm In Control Now"*	*"It Makes Me Happy"*	*"I've Lived Through It and I've Overcome"*
Sub-Themes				
• Time • Collaboration • Placement • Individual Needs	• Symbolism • Validation • Permanence	• Control of the story	• Reminder	

Time. The first expressive indicator that became apparent was time. Consideration relative to time was discussed by each participant. Kay explained that she "…had thought about the tattoo for a while." In fact, the process for her began after the third miscarriage. She talked about her initial considerations.

> You know honestly, I just didn't see one that appealed to me. I wanted it to ... I didn't want it to be like ... A lot of them had like babies with angel wings or feet print. I'm like I don't have any of that. I don't know what sex my baby was. I don't know if it had hair.

For Emily, time was spent reflecting on her initial choice as she saved the money to get the work done.

> There was a very big reflection process, because the tattoo artists had designed this, they showed it to me, and I went home and I journaled about it, and I couldn't take the drawing home with me because it was his intellectual property. I hadn't paid for it yet. I had instantly gone home and wrote down what it looked like. At that time, I felt like she was too beautiful for me.

This reflective process and consideration continued until she got the tattoo.

Other participants also spoke of the time involved. Sara considered the one she obtained for nearly two years. She also observed that she spent greater time on the trauma tattoo than on others.

> I put more thought into this tattoo than I did the others, definitely ... And I've definitely put more thought and more time into where is it going to be, what is it going to be, like, the exact position that I wanted it. And granted the other ones are not as, important in their position ... But like the orientation of it, and the exact position it was going to be,

> and where I wanted it, and the design process, and just the whole thought leading up to it. There was so much more involved than there was in either of my other tattoos.

Jamie scoffed at the notion of doing this quickly. She specifically mentioned that her tattoo was not done under the influence of alcohol, alluding to the oft heard story of someone obtaining a tattoo in such fashion, with little to no thought beforehand. She noted, "I had a clear mind. I had been thinking about it." Sophia also discussed how she took time to consider what she wanted as she did not want to "regret" her choice.

> I was like, I need to be 100% sure when I go in to get these that I'm not going to be wishy washy when I get there. I was like, you're going to think about it and you're going to think about it for a long, long time before you actually get this.

Kassandra had considered getting tattoos before her trauma but was never moved to do so prior to the event. She talked about the time she took to carefully consider what she wanted.

> I felt that it was something that changed everything about my life, that I wanted something, but I wanted it to be something that was positive and empowering, so I think it took a long time to think about it in terms like that

She noted this thinking through process took three to four years, putting "…a lot of thought into it". Each participant careful considered their decision before going through with it. In some cases, this process took years.

Collaboration. Tattoos are not normally viewed as an expressive art, as the bearer is not typically the one creating the art. However, the process of expression for these participants reflected personal involvement and working with others in terms of the design and appearance of the tattoo they wanted. Emily discussed this collaborative process at length. Having already gotten previous tattoos, she had an artist she worked with closely.

> I told him, "This is the idea that I want in a piece. These are the things I wanted to represent. Can you draw that?" I did not give him any physical guidelines. I just gave him emotions. What he ended up drawing was this very large, powerful fairy with a lock in her chest.

She continued to remain involved.

> I asked him to draw something powerful, something beautiful, and something completely in control of what's around her. I did tell him I wanted it to be a feminine figure. Those were the only guidelines I gave him. Every few days he would call me and he would say, "What do you think about bubbles?" and, "What colors do you like?" and I would tell him. I was very involved throughout the design process. He called me back down and showed it to me, and I just burst into tears. He was like, "Does that mean you hate it or you like it?" I was like, "No, it's perfect."

The collaborative process to get things just right continued as a thread with other participants. Kay's sister listened to her ideas and helped develop possibilities with her in a back and forth process. After sending these to a tattoo artist, she was presented with something that matched her vision, "…this is it." Sophia also discussed her involvement in the design process.

> I knew that I wanted it to say *this too shall pass*. I knew I wanted it to be not 100% cursive and I didn't want it to be print. I needed it somewhere in the middle. I looked on Pinterest and I looked on all these websites. I looked at fonts for tattoos. I couldn't find one that I liked. I was like, this is a lost cause. I'm never going to be able to find a font that I want this tattoo to be in for the rest of my life.

But she did not stop there and talked about finding an artist that was "…right for this one." She consulted with someone else and discussed going through versions of what she described as

never hitting on exactly what she had in mind. Finally, the artist decided to hand draw what she had been describing and she recalled her reaction.

> He drew it and I looked at it and I was like, that's exactly what I wanted. I don't know how you got that from the poor description that I gave to you, but that is exactly what I was going for the entire time.

She concluded by highlighting the collaboration and trust with this artist, qualities absent in prior tattoo experiences that had made her uncomfortable.

> He talked to me the whole time. He was making jokes. We were laughing. He worked with me. Anytime he wanted to change something he asked if it was fine. If I decided I didn't like what he was doing, we changed it.

This collaboration was an important aspect of the expressive act. It seemed to take the place of first person expressive art and positioned participants to be an active part of the process. The need for a personal means of expressing their trauma experience was felt throughout participant interviews.

Placement. Body placement is described in this study within two separate contexts. The first is considered in relationship to expression. Positioning was a factor in terms of how the tattoo was experienced. For example, Kay described her placement decision, "at first, honestly I thought I wanted it over my heart so that they would always be in my heart and I thought well you know I really don't. I don't need that. They're always in my heart". She also talked about the idea of placing in on her chest, but decided against it because she then would not show it, "…it wouldn't have that *presence*". This was important because she wanted people to see it.

Similarly, others considered placement. Emily talked of keeping her tattoos in a place where they may be covered at work because she felt that was "…more professional". Sara also

"…really thought about it for a long time." She wanted to work with children, so made sure she got one where it could easily be covered. Jamie agreed, "I wanted it somewhere where I could choose when it's shown…", due to requirements at her place of work. Still, in light of work and other professional considerations, it remained important to participants that a place was selected so it could be shown when they wanted.

Individual needs. The final expressive sub-theme of individual needs and investment was also a consistent one across participants. A sense of this act *needing* to happen was communicated; it almost seemed as though they were propelled to do so. And participants were not swayed by what others thought, nor by the presence of other obstacles. Several alluded to the past stigma associated with body art and talked of significant people in their lives who frowned upon it. For example, Sara discussed the aversion to them by her father. She described a previous episode when she got one on her wrist, and was told by him that she needed to get rid of it. Jamie discussed the importance of it meaning something, especially in light of the previous societal views associated with them. Kay noted her mother's view of women with tattoos as "hussies". And Sophia mentioned people who "look down on it" in addition to her mother who is not fond of them. In terms of other obstacles, Emily spoke of the sacrifices she made to get her tattoo.

> I was also very paycheck to paycheck, robbing Peter to pay Paul on my bills. Um, I was saving $5 or $10 a week towards this tattoo. It was a very small amount. It was like, I'm not going to eat lunch today so I can afford this tattoo.

Nevertheless, their needs persisted in the face of such objections.

It seems that acquiring a tattoo helped participants express themselves in their own individual manner, and in ways they would otherwise be unable. Sara has some artistic talent and

was the only participant to design a tattoo from scratch. She went through several different versions before finalizing her design.

> I think I ended up with a heart-shaped leaf because it was like a matter of the heart situation almost with the ex-boyfriend. I did try to do a maple-leaf, and I did try to do an oak-leaf, because those are species of trees I really like, but they didn't speak to me the same way this simple, I mean, it's not true to any tree that I know of, but it spoke to me when I finished drawing it and I really liked it.

Sophia also discussed finding just the rights means of expression.

> To me, if there's a thought that won't go away, the thought needs to be thought. The thought needs to be acted on. Something needs to happen. It's not going away for a reason. This one just wouldn't go away. I was like, I could paint it on a canvas. The canvas could get ruined. I could do a lot of different things and put these ideas into effect. None of them felt right. I'm going to go with my gut feeling. If it doesn't feel right, it's probably not going to happen. Every time I thought about inking it, putting it on my body, it felt right. I felt like it was something that I was being not pushed to do but it was something that felt like it *needed* to happen.

Kassandra echoed the idea that tattoos help to express oneself.

> I guess I feel like getting tattoos is like a way to express yourself. It says something about you, because it's not something that everybody chooses to do. I mean, obviously it's gotten way more popular in the last couple years, but I always knew that I always wanted them. It was different. I mean, it's art. It's art that you can put on your body to represent anything you want, or to say anything you want, or even if it's just something that just

> you know you have, it's something that you can look down at or look at, and you know why it's there and what it means.

Kay concluded, "some people write poetry, some people sing songs. I can't do that, so I have to find a way to get my feelings out there, and that's how I do it." Participant tattoos become a way for them to express themselves. And in some cases, they became the desired or only means of needed expression.

Theme 2: "I Want It to Mean Something"

Participants described the aftermath of the trauma event as characterized by a sense of confusion, searching for answers, and feelings of unfairness. One described it as a "crisis of faith", while another questioned her spirituality. It appears all were searching for meaning to make sense out of what happened. This need for meaning extended into the decision-making process related to getting a tattoo. All the participants spoke of their tattoos needing to mean something.

Kassandra discussed her meaning-making when asked what was different about her trauma tattoo.

> A lot of meaning, and they're all very significant to me, but this one obviously was different, but it's really, it's just more for me. I get tattoos for me are for specific reasons and specific meanings … All of them are very personal to me and mean something. It's like a process that I go through.

Sophia recalled what it is like when people notice and inquire about her tattoo, "what's the story behind it? Then I'll tell them and they're like, oh wow. It's not just a random thing that you have. I'm like, no. It actually means something." She continued to describe this importance.

> Most things that are tangible, mean something. If it's going to be somewhere important, it's going to have a meaning whether people see it that way or not. I don't know. It's hard to describe. If it's going to be important to me, it's going to have some tie back to something in my life.

Kay also discussed her need for meaning in her tattoo.

> I always said to myself when I get my tattoo I want it to mean something. I don't want to get just like a heart or a flower, anything like that. I want it to mean something. I want it to have meaning … For me, I just really didn't want ... If I was going to have something permanent I wanted it to mean something.

Finally, when an artist made a sexual innuendo about the placement of Sara's tattoo, she remarked, "that's not the point, that's not the point at all." In this way, she confirmed with her rejection of that comment that the tattoo held specific meaning for her.

Symbolism. The process of meaning construction through the act of getting a tattoo seemed to be primarily expressed through their symbolism. Once participants realized it needed to mean something, and after careful consideration, they all arrived at highly symbolic representations for the images inked into their skin.

Kassandra discussed the meaning her tattoo holds for her. It is a quote, *I'm not what happened to me, I am what I become of it*.

> I could have gone in a totally different direction after what happened. I could have not gone to school. I could have stayed locked away forever and not made all of these really great relationships that I have in my life with friends and coworkers, and keep climbing up in my job, and keep getting promoted. There are so many different ways it could have gone, and I could be in a really terrible spot right now. I could have let it totally control

> my life, and it did for a while, but I think that was part of it too is that I'm in control now. I'm the one who decides that this is going to make it or break it. I didn't want to be broken over it anymore.

Sophia also discussed how the tattoo signified a point of resolve and acceptance.

> Now it's like I'm finally at peace with what happened. I can accept it. Now it's fine for me to put it on my body because I can talk about it. It's not painful to talk about. It's just there. It's part of who I am now. It's why I act the way I act sometimes. It's there and it's done with.

She also discussed how this meaning developed for her.

> I just go into that's what my mom always told me growing up. My parents got divorced it was a rough situation. She would always tell us that. It reminded me that everything is going to get better. It might not be fine now but it will in the end.

She concluded, "it's like a show of strength because she was strong then."

Kay acquired a ribbon that signifies stillbirth and miscarriage, backed by angel wings. She discussed it as the "perfect" representation of her "angels". Placement on her wrist was also a source of symbolism, relating to a connection she couldn't have prior to the tattoo. For Sara, the symbolism related to change. She remarked, "I want a tattoo to symbolize that I'm not going to go back to that person, like I've changed, so I want something to symbolize that I've changed, that I'm not that person who left school."

For some, there was also symbolism embodied in the act of getting the work done. Sara discussed this:

> I was thinking about what it was symbolizing while I got it, so I almost felt like it was that final, you always linger, with a little bit of guilt, and feelings and the emotions that

> dredge up from the whole situation, and I kind of felt like that was a purge moment again, like that was a big, this is happening, and you're purging out some of the negativity that you're holding with you. Like the leaf is dead, that's the negativity, you're purging it out.

Kay also discussed what the act of getting the work done was like for her as related to the pain she had experienced.

> I just felt the pain that you go through with a tattoo, I could take that pain [clinches fists] and if I could take that pain and center myself and just sit through that tattoo, and I did. I didn't flinch. I didn't move. I didn't cry. I just took it. I mean I sat there the whole time. She was like, "Do you need to move?" "No." "Do you need to get up"? "No." I want this one solid. I wanted to take the pain.

And, in an interesting reversal of the role of pain, Emily remarked, "getting some of these injuries was very painful, but covering them up [with tattoos] hasn't been, which is its own weird blessing." Like many, Kay talked about the feeling of being "broken" that resulted from her trauma. She explained how her tattoo helped to symbolize accomplishment, "it made me feel like if I can do this, I've done something. I've taken what somebody can dish out and it didn't break me."

Jamie discussed the symbolism behind the butterfly tattoo she received, based on an idea she had seen once in a movie.

> That butterfly represents the transition from life to death. That it's not something that we should be sad about, that it's a beautiful transition. I'd never thought about getting a tattoo, but I wanted something to have with me to symbolize that transition, that my daughter had went, even though she wasn't really alive, she was alive inside of me, but that she died.

And Sara spoke of detailed inspiration for the one she received.

> I wanted it to be a leaf because I had decided with the fall leaf season, which is spectacular, that, you know, like, deciduous trees changing over their leaves and the changing of the seasons, and the change really spoke to me, and the fallen leaf, and like, leaves fall but the tree keeps growing, and good things happen … I just looked at it and I was like, like "that's the tree, like, that's my leaf, that's me changing, that's the fall". And the leaf is intentionally meant to be falling. Where I have it placed [she later explained as the trunk of her body] it's meant to be falling off of my body, it's on my leg. So, it's falling off of my body and it does symbolize the change.

She concluded, "I wanted something to truly symbolize that it was gone, that I was taking a step away from what had happened, that and I was okay to keep moving forward."

Finally, Jamie equated their tattoo symbolism as akin to a mark of recognition, like a traditional war metal, or a "badge" as she put it. She explained that it makes her "proud".

> It's like part of that memory is with me. It's something, it means something that I can carry with me every day and I survived [reflective pause]. You get war memorials when you're a veteran. This is almost like my war memorial so to speak.

Validation. For many trauma survivors, there is a sense of detachment following the trauma (Herman, 1997). Some even experience dissociative experiences as discussed in Chapter Two. There can be a general disembodiment from the proceedings of life that contributes to diminished functioning. There is a need to acknowledge what happened. Participants in this current study related their tattoos to validation of what had occurred in their lives. Kassandra noted, "all that mattered was that's what happened to me. Now that I've started processing, and

accepting it, and dealing with it in a better way I feel like it's not ... That's part of me taking the control back."

Kay described the validation she feels as her tattoo is symbolic of her lost children being with her, thus bringing the events into reality.

> Before I got my tattoo, it was like nobody wanted to talk about it. Nobody wanted to really think about it … They're with me because it just seemed like it gave them ... I don't know how to explain it. You can't deny that it happened. There was nothing before. My babies don't have a grave that I can go visit. I don't have footprints or hand prints or anything. I have a tattoo though and it shows that they were here, that *they were mine* [slower, measured speech].

She emphasized reality, it was real, "…it happened." The void, the emptiness, is replaced with a "…physical presence of what's not here." She concluded with a final note regarding the pain.

> Pain makes it real and I'm not numb. I'm not asleep. I'm not sleeping through it. This is happening to me. When I got my tattoo, I wanted to endure the same kind of pain that I had when I had my first miscarriage. It started with pain. I wanted it to end with pain … and I've lived through that pain.

While not explicitly stated, this need to acknowledge or recognize that the events happened seemed to be an important part of the process. In looking back over my reflective journal, I remarked about this quality of making the trauma real, "it seems as though the tattoo in some way makes the intangible…tangible."

Permanence. Some participants discussed the role permanence played as part of the process. There was an acceptance that getting this work done makes the symbolism a part of them. Sara spoke of her work being a "permanent sign" of the changes she has gone through,

"it's not something I'm ever going to be able to forget, it's permanent. It's in my mind forever." Sophia described this in discussing how getting a tattoo was different for her versus painting it on a canvas.

> If I put it on my skin, I guess it feels to me like it can't go away. With canvases, I ended up ... I get really tired of the stuff that I paint. I either give it away or it stays on my wall for a little while and then I'll paint over it and I'll paint something else. On a canvas, I could just paint over it. It never felt right because if I paint myself something, I find flaws in it all the time. I didn't want it to go on a canvas and be able to find flaws on it … Then I would end up either giving it away or just painting over it. I didn't want that to happen with any of it.

Sara distinguished herself from other people who simply collect tattoos, "I want mine to have meaning when I put them on my body because they are permanent." And Emily uses this permanency for direction, "it's created a standard that I can't change, because it's in my skin." Jamie also discussed meaning and permanency. She recalled her thought at the time.

> Wow, this is something that's going to be with me for the rest of my life. I want it to *mean* [emphasis placed] something. That's what I was thinking about because I wouldn't just go in and get something because it's cute, but if I'm going to put it on my body, I want it to mean something. Seeing this butterfly with all these beautiful colors, it meant something to me.

It was clear that these participants did not get their trauma tattoos for aesthetic purposes. Jamie summed up a thought shared by many of them, "I probably would not have gotten a tattoo if it hadn't have had some kind of meaning … It had a lot of meaning to me." And in this way, meaning construction becomes a permanent part of the person. This finding is consistent with

Herman's (1997) model and the need to make sense of the trauma experience to work on integrating the experience and begin moving forward in a productive way. It seemed for these participants the meaning of the process began with a symbolic overture connected to the event, and in many cases, evolved to also become a representation of what they've been through and overcome.

Theme 3: "I'm In Control Now"

Participants in this study discussed the disruption created by their trauma experience(s). A couple of them even used the word "trapped" to describe what life was like for them at the time, and all of them communicated a similar sense of their ability to function being seized. Kassandra's comment echoed and summarized a similar sentiment seen across these participants.

> When something like that happens it's not anything that anybody has any control over. I think that was probably something that I probably didn't even really think about it at first, but I mean, I had no control over it.

Getting a tattoo appeared to facilitate the process of regaining personal agency.

> There was nothing I could do. It happened, and here's where we are, and you have to deal with it now. I wanted me personally to feel like I had some semblance of control, like maybe I don't have control over what happened, but I have control over how I handle it now and how I deal with it.

Sara talked about her sense of regaining control by leaving the past behind. For her, a big part of this was learning to interact with men again and being able to establish trust. Reflecting on the meaning associated with her tattoo helped her work through it.

> Not bringing the baggage of the boyfriend, and trying not to bring the baggage of what I considered promiscuity, and rape into the future relationships, and allowing myself to

> make decisions based upon people that I met, so becoming less concerned about meeting strangers. Becoming more comfortable again with random guys … I wanted to be able to trust guys again.

For Emily, the process of regaining control was a corporeal one, related directly to the abuse her body had taken, emotionally and physically. She recalled thinking, "Okay, he didn't like my body, but that doesn't mean that I don't have to like my body."

> What I ended up doing, because I realized that he had so emotionally torn me down and physically torn me down, I wanted to do something for myself that built me back up and gave me that independence again, especially over my body, because he insulted the way that my body looked. He physically attacked my body when he got angry. I wanted to reclaim that part of myself again.

She continued talking about her need to regain control and not be dependent.

> I want to be one of those people, that people can turn to. I have people in my life that if everything went wrong in one day, I know I could call that person and they would be there. I wanted to be one of those people for other people. I also wanted to be one of those people that was not dependent on others. I don't want to be somebody, somebody who's small. The way that my ex-husband made me feel was very small. I want to be one of those people who is in control of the things that go on around them, even the smallest thing.

She concluded by talking about how the process related to the tattoo represented the strength to move in that direction, and how she never wanted to feel defeated again, "I don't ever want to be that person."

Jamie was the only participant that did not highlight some significant aspect of control, however, she did mention how the process of getting the tattoo was associated with the need to gain control of her unhealthy coping strategies. So, control factored into the process for everyone. The idea of "needing it" also reappeared here. This *needing it* reflects the need to regain or achieve a new sense of agency. Emily described it as, "…being willing to remake myself into something that was acceptable again…" A large part of this process appeared to involve taking control of their stories.

Control of the story. A very strong sub-theme related to participants' reclaiming control appeared within the context of the way they tell the story of their experiences to others. This marks the second appearance of tattoo placement. While expression was part of the decision-making process, so too is deciding how, when, and to whom their stories are told.

When asked about placement, Sophia noted that she questioned, "am I going to want people to ask about it if it's somewhere they can see it?" Kassandra explained, "I think it goes back to the control thing again, because it's something where if I want to cover it up, I can, but if I want to have it out there, then I can too." She discussed not wanting it to be visible all the time.

> I didn't want people at work asking about it or someone to be like, "Oh. Hey. I know where that's from", because it's really just more for me. I didn't do it to show it off. I did it for me to have some kind of control over it, because I felt like I was in place in my life where I was ... I don't know that you're ever okay with it, but it is what it is. You still have to live your life. It was really more for me, but … I can decide who sees it and who doesn't.

Sophia expressed similar feelings about revealing the tattoo, and ultimately her story, to others.

> I was like, where can I put it that it can be hidden and I don't have to show it if I don't want to? That if I go into a work place that isn't really tattoo friendly, I can cover. Or if I don't really feel like talking about it that day, nobody is going to see it. I decided that I was going to go with my wrist because its ... I was going to go with a size that was small enough for a bracelet to cover it if I wore long sleeves.

Jamie also affirmed placement as related to managing her story.

> You carry this story with you that a lot of people might not know about because my tattoo, like I said, it's on my ankle, so depending on what I wear, it can be seen. People can look at it, but they don't know what it means until they ask … if I wanted to show it, I could wear shorts, but if I needed to cover it up…then I could. That's why I chose to put it there.

Sara discussed her needs of placing the tattoo somewhere to ensure her ability to retain privacy.

> And then I was thinking about, where could I get the second one that was an okay place that I could cover it up when I wanted to, that I could show it when I wanted to, that was personal and private, kind of, like it was important to me that this tattoo almost be private, because it was my private struggle.

She concluded by placing a strong emphasis on being in control of revealing it to others.

> I wanted to be able to wear any clothing that I normally would wear without it being readily apparent unless I *wanted it to be*. So, if I want people to see it I can wear clothing where you can see. If I don't want people to see it, I can wear clothing where it's not apparent.

Interestingly, one of my primary assumptions going into this study was that tattoo acquisition would help participants tell their story. And, this did appear to be the case overall as

the process involved helped them to begin feeling like themselves again; feeling whole as described in these themes. Some of the participants directly mentioned that it made telling their stories "easier". However, the thematic element related to storytelling for these participants was consistently discussed as being more a function of control. Sara noted that the story process involved with her trauma tattoo differed from that associated with her others, "…this one, if I want to share it with you, I will tell you I want to share it with you." Kay also discussed how it helps communicate the story.

> I just really wanted it to be something where people could look at it and they understood what it meant. I didn't want to have to answer a thousand questions about oh, where's your baby at now? What's this mean? How many babies do you have? Did you have babies? This kind of shows that I've never had my children with me, but they're always with me. When you see that you don't have to question and ask a thousand things because for the longest time it was real hard for me to talk about.

The experience of striving to regain control witnessed in these participants is consistent with the conceptual literature theorizing the psychological purpose of tattoos. I remarked repeatedly in my notes about the emphasis participants placed on finding some way to get their footing. The act of acquiring a tattoo seems to be a marker of resolve related to a prior sense of not being able to escape, shifting into increased agency, where the bearer begins to take control again. Kassandra summed it up this way, "I think it was kind of like a control thing for me to take back some control … there's no shame. It's not my fault that it happened. It did, but look at what I can still do."

Theme 4: "It Makes Me Happy"

One of the major contextual elements described by participants as they tried to recover from their trauma experience was engagement in unhealthy and ineffective coping strategies. They described a range of behaviors. These included promiscuity, overspending, avoidance, and other maladaptive activity that hindered their emotional progress. In most of these cases, it seemed getting the tattoo, became a more adaptive, positive means for coping. This became apparent through their consistent descriptions of them bringing comfort. Participants also noted the proximity of their tattoos verbally and by touching or pointing to their work. Because it is permanent and on their bodies, there is a closeness that translates into availability whenever needed.

Kassandra discussed how she uses her tattoo, what it is like to look at it.

> I think it helps me, especially on bad days, to look at it and think, "Yeah. Today sucks, and it sucks that that happened, but don't forget where you're going, and don't forget what you've done and what you've overcame to get to this point. You didn't let it break you."

Similarly, Sara noted that it makes her "happy" every time she looks at her tattoo:

> Every time I see it, I look at it and think "yeah, I survived that", like, I made it through and I'm a better person now. You know? I like myself more now than I liked myself in college. I like the person I've become, and without those events I wouldn't be this person. For better or for worse, that's part of me, so it makes me happy.

Sophia also discussed the comfort her tattoo brings. I noticed several times during our interview that she was holding and rubbing the wrist with her tattoo. When asked about this, she talked about it from a standpoint of solace.

> I've noticed that in times where things haven't gotten hard. I'm questioning whether what I'm doing is right or if I'm making the right decision or if people are really annoying me that day. I notice that I'll run my hand across it [grabs wrist and then rubs tattoo with her hand]. I'm like this might not be fine now but it's going to be fine in the end.

She also mentioned she finds herself touching it when she thinks of people it represents. She concluded her story by speaking about its calming effect during times of high anxiety.

> I guess in stressful situations it triggers that I have it and that I got it for the reason that I can calm down with it … I can think about all these things and how bad things are going to get, but odds are it's not going to get that bad. Just having a physical reminder that I can read and that I can see, reminds me that it's probably not going to get that bad and that it's fine and that I can just breathe again.

Kay also discussed a calming effect she experiences and affirmed, "it's my way of coping. It's what I do."

> Before I got the tattoo, I would sit and talk to my babies because I know they're around me, but now I have that connection. I have something to focus on. I have a point and they're over my pulse. They're part of me. [long, thoughtful pause] It's the connection that any other mother would have with their children. I have that now.

She also discussed the manner in which this calming plays out for her.

> Like there's a reason to keep going and something to look forward to and that's how I feel when I look at my tattoo. Sometimes it's even like, if I'm having a bad day. I'll be at work and I'll just kind of go off in a corner to myself. We have these little sitting areas. I'll sit there and be like, yeah. I don't have to worry. You're with me and it calms me

> down … This is my family. I have my family. I hold them in my arms [points to each, crosses her arms, and brings them to her chest].

Finally, Emily noticed that having other people respond positively to her tattoo also has a positive effect on her, "having other people appreciate the fairy, even if they don't know why it's there, helps me appreciate it and myself more, because I've taken a really, really bad experience and put something beautiful in its place." The presence of the tattoo provides the bearer with a means for focus, reflection, and calming.

Reminder. As discussed in Chapter Two, acquiring memorial tattoos is a popular practice and is an initial way trauma has been connected to the practice of tattooing in the literature. These participants all discussed using their tattoo in ways that helped to memorialize and remember; something that helped bring comfort.

Sophia discussed making the decision to ensure she could see the tattoo, and use it as a reminder as she needed.

> I was like, I probably should hide this one but I don't want it to be so hidden that I can't see it if I need to be able to read it and remind myself of it. I ended up putting it on my wrist because I can cover it with a watch or bracelets or whatever I decided to wear. But it's still right there. I can look down and I can see it.

She spoke of others being able to see it in case "…they needed that phrase."

Kassandra also mentioned *reminder*, saying, "I think that's more of what it is for me is like a kind of silent reminder like, don't give up again. You don't have to let this control you." Kay affirmed the impact of these reminders.

> I still have that reminder, yeah and now I have my babies, so I can hold my babies when I want to. There are times, I'm not going to sugarcoat it, I will kiss my tattoo. It just makes me feel better.

Jamie tied remembrance back into her reference of the tattoo being a "badge".

> When I look at it, again, it goes back to I'm proud of how far I've come. It won't ever let me forget what happened. It won't ever let me forget about her because, and that's another thing, after the first year, I got really upset with my family because I'm like, "You all have forgot about her". When you have somebody that goes through a loss like that, you really don't forget about them. You just don't know what to say to that person. I wanted something to always remember her by, something other than a grave site and a few pictures, that's all I have. This is something, again, I carry with me every day.

Tattoos for these participants seemed to be a permanent reminder of what has been endured. Sara mentioned it this way, "it's a permanent reminder of what happened, but it's a permanent reminder that I got better, and that I'm okay, and that I can do what I have to do to become okay as well." The permanence seemed to allow participants the opportunity to sit and reflect, a process that brings them peace. The tattoos become an active means for coping, and in a way, help replace pain with hope.

Theme 5: "I've Lived Through It and I've Overcome"

As previously discussed, the idea of post-traumatic growth is an emerging one within the literature (Weiss & Berger, 2010). The evidence to support such growth is mixed to date. However, the final theme identified among this group of participants directly relates to personal growth following their experiences. At first, I considered aspects of what they were talking about as attached to the aforementioned meaning-making process. But upon further readings of the

text, it stood out as more related to an actual outcome associated with the tattoo acquisition process.

Emily discussed the changes she noticed in herself after getting her tattoos. She noticed more confidence, “I don’t mind to show them [scars] off now … I felt confident to actually show more of myself. Now I don’t mind people looking at me and looking at my skin where those scars have been.” She also mentioned overall change, “I’ve changed it. I can look at it and admire it, and I can admire the changes that have come in spite of it.” She also spoke of becoming more decisive.

Growth appeared to present itself most through changed perspectives. Kay discussed getting another tattoo to signify finally getting to a place where she has accepted what happened and can move on with a changed outlook.

> My babies will always be with me, but I’ve let that pain and the hurt kind of just take over my life for many years and they know I love them. They’re in my heart, but I can’t let it dominate my life anymore. Again, it’s what made it cathartic is I’ve come through the other side and I may be broken, but I’m still good. There’s still good going to come from all this…”

Sara also discussed her tattoo within the context of change, both from the impact of the trauma and the behaviors in which she engaged following it, that extended from the symbolism of her tattoo.

> I needed something that was, all of that was gone, and this is a permanent sign of, I am a new person and I’m starting fresh, because that’s what, tree’s start fresh every year. The leaves fall off, and they start with brand new leaves every year.

And this helps her understand and say to herself, "…yes it happened, but you're more than just that, you're more than just this, and that's okay." She has also come to realize, "I'm more comfortable with myself now, and I'm more assertive with my opinions."

Jamie discussed a dramatic change in her perspective, and directly noted growth, following the process of getting her tattoo, "I'm definitely not the same person I was when I got the tattoo. I feel like looking at me when I got the tattoo to now it's two different people because of the growth." She concluded, "I've lived through it. I've overcome the obstacles, and have improved." Sophia also noticed change, along with a sense of resolve.

> I guess the tattoo reminds me that I am the strong person that I grew into because of it. If it's something that I want to do, nobody else needs to have an opinion in it. I can listen to their opinions and I can be like, that's a fair point. I should take that into consideration. At the end of the day, I decide that I want to do it anyway that's fine because that's what I want. I don't know. It'll be okay.

Kassandra concluded by explaining how the process of getting the tattoo grew into a recognition that she had overcome her experiences. She told herself, "Okay. Look at what you did. You went through all this, and all of the stress, and anxiety and depression, and now you did what you wanted to do." The struggle to get to this point replaced a previous feeling of being defined by her trauma, "…I felt very defined by it, and that this was all I would ever be for the rest of my life, was another statistic."

Based on these descriptions, it became clear the process of getting the tattoo not only helped the participants process the trauma(s), but also facilitated a movement forward. In listening to these survivors, there was a palpable sense that they *made it*, they survived what happened to them, and overcame. Furthermore, despite the trauma history, they seem to be

changed for the better because of the work they have done, citing new perspectives, behaviors, and attitudes that have developed. They were empowered in ways unknown to them previously.

Outlier

There was strong agreement of the above themes across all participants. However, there was one individual who talked about her experience in a way that was uniquely different from the others. Such outliers are important to identify as they can provide information and perspectives that would otherwise be lost, while presenting additional perspectives for consideration.

Emily discussed similar themes of her tattoo being related to or representative of her desired self or life direction. However, unlike other participants, she took this influence a step beyond in a very active way. In a sense, the meaning of her tattoo became integral to her thought and decision-making processes. She described the reasoning behind this guidance as follows, "this fairy with all of her power and grace wouldn't make those excuses in my mind. If it was an excuse that wouldn't be ok with her, then it shouldn't be ok with me." She provided a specific example of this influence in action during a recent job interview.

> I've had this tattoo since 2013. This interview was a year ago with this administrator. Because I have used this as my decision-making process for so long, it takes less time to measure it up. It was very easy for me to look at this person and say, "You know, I know we're only halfway through your interview. I appreciate what you are telling me about your school. This is not a fit for me. I will not be happy here. I don't want to waste any more of your time."

She continued by explaining that this new way of processing makes her, "…much more deliberate and much more conscious of the consequences that decisions do have…" when she

makes them. Others notice this behavior change as well. For example, she discussed how her new way of working through decisions has provided her father with "…more piece of mind" because she is more decisive, and less impulsive.

She provided another example of living up to the "not going to take it anymore" standard represented by her tattoo in a decision to end a relationship in which she believed she was being taken advantage of.

> I think that if I hadn't created this set of very strict principles that this fairy would live by, maybe it would've taken me longer to get to that point. I still would've gotten to the point of, "Okay, this guy's taking advantage of my monetary kindness," but I don't think I would've realized it as sooner.

She continued by explaining that these strict principles the tattoo helped her create, makes it easier for her to draw a line and say, "…we're not crossing it this time." Her tattoo becomes a motivator to act differently, to live up to what it represents. So, in addition to being a *source* of reflection and comfort as with the other participants, Emily's tattoo became a *driver*. She embodied the symbolism and meaning of her tattoo and uses them to direct and support behavior. While still consistent with overall themes, especially meaning construction, her usage marked an interesting difference.

Philosophical Insights

The methodological approach for this study is grounded in philosophy. While attending to the specific findings discussed in this chapter, I would be remiss to not include a brief discussion of important relational qualities noticed during this study. While not identified as major themes, these other aspects seemed to provide further context, or the foundation, on which

participant experience played out. These include body and identity, elements that help to reveal the nature of this phenomenon.

The Importance of the Body

Temporality, corporeality, spatiality, and relationality are all important to the phenomenological understanding of experience (van Manen, 2014). Time was already discussed above as a sub-theme of this study. Time not only reflected the thought participants gave to the process of tattoo acquisition, but could also be considered in a longitudinal way to help understand participant progression of experience. However, the body kept reemerging at the forefront of experience with these participants. The realization of changing the body is reflected in each of the participant's thoughtful considerations before going through with the act.

Thomas and Pollio (2002) discussed the emphasis that Merleau-Ponty placed on the body for understanding individual experience and noted that *embodiment* means "…experiencing and understanding the world by, and through, the body" (p. 12). For Merleau-Ponty, "…the body was the vehicle through which we have a world and the means by which we can sustain communications with it" (Schmidt, 1985, p. 43). Thus, the body takes up a central primacy in our ability for perception, communication and ultimately, understanding. It is as if the body as a whole is capable of speaking. And indeed, is the "…focal point of living meanings…" (Thomas & Pollio, 2002, p. 51).

In most cases, the body featured in an undeniable way as participants continually referenced it in terms of abuse history (in some cases), the site of control reclamation, tattoo placement considerations, and immediacy (closeness) related to coping. When talking about the significance of the tattoo being in the skin, Sophia remarked, "it's just part of me." Emily reflected before making a change to her body, "I also wanted time for me to know that was going

to be *in my skin*, and absorb everything that it represented." Sara also emphasized the tattoo becoming part of her, "…those changes, those things that happened, they're a permanent part of me", just as her tattoo is a permanent reminder that the past does not define her.

The body factored for others in terms of permanency. Sophia questioned this during her decision-making process, "is that something that I'm going to want to hold onto for the rest of my life? Am I going to want to look at it every day?" This permanency also reflects the tattoo becoming part of the person. She continued and discussed the tattoo as being akin to a body part, "…it's like my arm. It's always going to be there." Kay echoed this as well, "they're always with me". And she demonstrated this to me by showing how she can literately bring her arms into her body and hug her lost children. Sara spoke of it as marking the permanency of the change she was going through, "…obviously, a tattoo's permanent, but the idea of cementing the change is permanent, so, a lot changes." The fact that this expression and modification took place on the body also acts to keep the meaning, symbolism, and ability to reflect close and intimate.

Finally, participants talked about the significance of pain during the actual tattoo process. The pain was experienced as more than what is typically felt when the needle inserts the ink into the skin. Sara commented about this realization.

> This one hurt more than either of these two [pointing to them]. The one that's the new tattoo, and I swear, like, the pain was almost mental, too … I don't think it was just the pain of the actual … like it hurt more.

So, the pain she experienced was perceived by her as being different, more "mental", from that which she had during her other tattoos, and she attributed this directly to the process she was going through related to the trauma. Kay talked about the act of getting the tattoo as one that proved she could feel and endure the pain of her experience. Emily spoke about the impact of

abuse she suffered for years including scars, bruises so deep they would "…come back out of the bone to the surface", and subsequent weight gain. She spoke of re-accepting her body through her tattoo work.

All the participants related an experience of being "broken" by the trauma event(s), and in some cases this also represented the physical self. The phenomenological importance placed on embodiment and experience is supportive of the conceptual literature that discusses the meaning tattoos can have for the bearer. Merleau-Ponty (1968) asserted, "the flesh is the body inasmuch as it is the visible seer, the audible hearer, the tangible touch - the sensitive sensible…" (p. liv). Relative to tattooing, Featherstone (1999) suggested bearers use them on the flesh as a means for constructing a coherent sense of self. They are intertwined with personal narrative (Sweetman, 1999). In the case of this study, tattoos became inscriptions on the broken body. And the body, while for many of these participants the very place of violation during the trauma, also became the means for reflection, reclamation, hope, and re-construction.

The Connection to Identity

If we accept the significance of the body as espoused through the phenomenological explanations of Merleau-Ponty, then it stands to reason that the thoughtful manipulation of the body says something not only about the individual's perception of lived experience, but also their sense of self and identity. Merleau-Ponty (1945/2014) made this connection to self. In *Phenomenology of Perception*, he observed, "…by thus remaking contact with the body and with the world, we shall rediscover our self, since, perceiving as we do with our body, the body is a natural self and, as it were, the subject of perception" (p. 239).

In a variety of ways, participants' understanding of themselves changed because of getting a tattoo. Emily discussed her changes to self as transformative.

> The combination of knowing that I was going to get this on my skin to represent the way that I wanted to see myself and I wanted to live up to how I saw myself …I also felt like I was becoming this figure that he had drawn to go onto my skin.

She took active steps to live up to what the tattoo represented for her, "I felt like it wouldn't be right for me to have that tattoo and not be in the direction of that person." For her, it changed the decision-making process and resulted in a person not ok with "making excuses". She concluded, "I feel like the tattoo, it's given me permission to be more honest with myself, and to create guidelines I wouldn't have normally thought about" and "I'd felt like my skin was ready to receive it. I was ready for that to be a part of me, because [she thought about her tattoo for over a year] it had already become part of me ideally."

Sara discussed her tattoo as related to the person she wanted to be, "I wanted something I change not only from the person who had the bad relationship and the girl who got raped, but what I did afterwards as well." She concluded, "…it was for me, it was mine. It was very much like, this is about me, being me, and coming to terms with, me..."

Participants also spoke of their tattoos in a way that reflected their connection to self over time. Kassandra spoke of how a person changes over time, and imagining that the way she looks at her tattoo will evolve with her changing self, having already experienced some of this.

> I think it's kind of sometimes one of those evolving things, like as you evolve as a person you look at things differently, or you have a new outlook. I mean, I feel like the tattoo is the same for me, because as I get older, have more experience, or change my outlook, I think it will probably change with me, because I wasn't the same a year ago, and I won't be the same a year from now. Maybe it will mean something totally different, or maybe I'll view it in a different way … the two [trauma] are obviously related. I'm not ever

> going to look at it and not think about it, but as you kind of process it, and accept it, and get to a healthy place I think the meaning of it has to change. I mean, I guess it doesn't have to, but what's the point of not evolving it with your different outlook. You know?

Sara expressed a desire to not change a thing about her trauma tattoo, a sentiment different from her others.

> It doesn't get changed, it doesn't get touched up, it doesn't *need* [emphasis placed] touched up. It's okay for it to fade. And I almost wonder if I'm like, memories fade, things fade with time, the tattoo should fade with time, like, whereas, I'm probably going to get my other tattoos touched up. But I don't ever want to get that one touched up … I think it's just a connection to the fact that it has its deep and personal meaning and its, it is what it is, and I don't … I don't want to mess with it.

So, while different in perspective, there is still a notion present that the tattoos have become a part of the body, and thus, the self.

Like growth mentioned above, it is possible that other processes such as maturation or simply timed passed may account for these shifts. However, the participants all talked of this process in direct relationship to their tattoo acquisition. As participants used this process to help cope and regain control, the meaning and symbolism of the tattoo appeared to represent aspects of a desired self or direction as they strove to reconnect with themselves and others. The act of modifying the body resulted in changed perspectives related to a greater or modified understanding of who they are. And this may evolve over time as the permanence of the act seems to embed symbolism into the self.

The Essence: From a State of Brokenness to One of Evolving Wholeness

Continual work with the data, and reflection on the above context and themes, help to provide the overall *essence* of lived experience. The act and process of obtaining a tattoo for these trauma survivors helps *facilitate movement from a state of brokenness to one of evolving wholeness*. The qualifier *evolving* is used here to indicate that participants are moving in the direction of, or grasping, a sense of wholeness, yet recognize the process is ongoing. Several participants directly addressed the fact that recovery is still a work in progress. As Kay observed, "there's still healing going on."

I did consider the question of what came first within the recovery timeline for participants; improvement or the tattoo. Considerations might be somewhat different if tattoo acquisition occurred as a denouement within the recovery process. However, it became clear that tattoo acquisition was a thoughtful and active part of each participant's individual experience. Thus, the process surrounding tattoo acquisition was a facilitator rather than an outcome.

This overall essence is illustrated in Figure 2. The context of the original trauma event(s) in the broken, disrupted circle represents the myriad of emotional consequences as experienced by survivors. Progression is further marked with elements commonly noted in this group as they attempted to move forward. These included a withdrawal from life, ineffective attempts at coping, and searching for reasons why the event happened. Tattoo acquisition is represented next and is surrounded by the identified themes presented is dashed circles. These themes are intentionality situated to help further illustrate the progression of experience. For example, expressive aspects, meaning construction, and reclamation of control appear to occur first. This is then following by a sense of comfort and growth. Finally, these are all presented inside a large

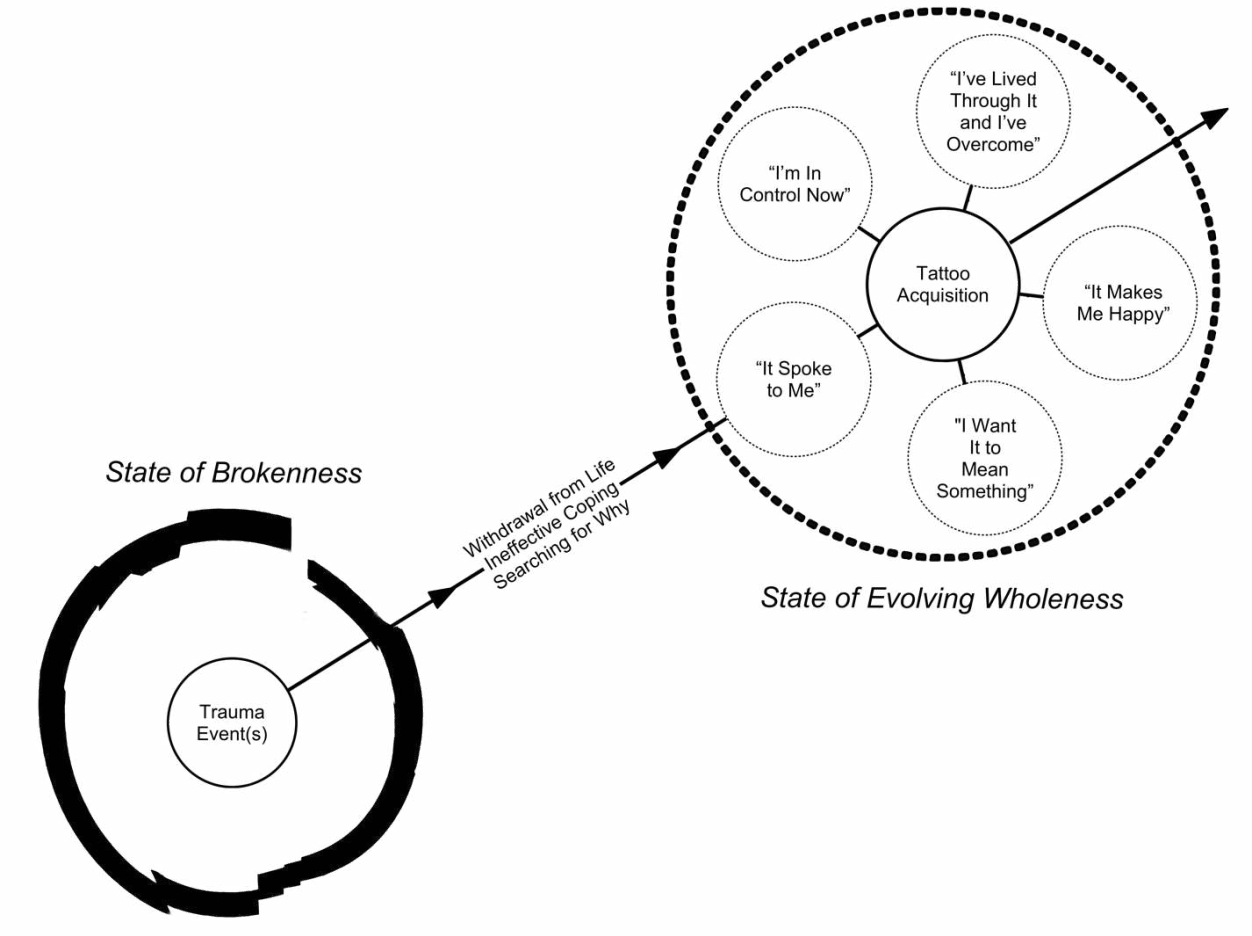

Figure 2. *Trauma Survivor Tattoo Acquisition: Context and Thematic Relationships*

dashed circle that represents the reemergence of wholeness, even though that process is at various stages of incompleteness depending on the individual.

Summary

This chapter presented the findings of this study on the lived experience of getting a tattoo following trauma. Participants discussed the disruption they experienced in the aftermath of their traumas. They all struggled with coping as they tried to find a way to move forward. And they all used tattoo acquisition as part of this process. This process was characterized as a thoughtful, expressive act; one in which meaning construction and reclaiming control were important aspects, leading to comfort and growth. In conclusion, participants all experienced the act of getting a tattoo following their traumas as a beneficial, positive one. It helped them move from a state of brokenness. A discussion of these findings and related implications are discussed in Chapter Five.

Chapter Five: Discussion and Implications

The purpose of this study was to examine and contribute to the understanding of tattoo acquisition in adult survivors of trauma, and related ameliorative or therapeutic factors. To investigate these phenomena, I used a hermeneutic phenomenology approach. This type of phenomenology seeks to not only offer description, but also interpretation of lived experience. Such exploration involves deep engagement with the topic and research participants. Sharkey (2001) explained, "dialogue partners get lost in the conversation's subject matter in authentic conversation and it is this 'getting lost in the subject matter' that leads to genuine understanding and interpretation" (para. 5). The significance of this study may be demonstrated in a couple different ways including, 1) it helps to fill a gap in the knowledge base regarding the psychological meaning and influence of tattoo acquisition for trauma survivors and 2) through new information provided to mental health clinicians working with this population and searching for ways to help support recovery. In this chapter, I provide a final discussion of the key findings as they relate to the theoretical structure used in addition to previous research. Limitations are presented along with a discussion of implications focused on counselors and educators. Finally, recommendations for future research are provided.

Discussion of Primary Findings

Time spent with participants and their stories revealed common themes as presented in the previous chapter. Interaction with participants involved the process of Gadamer's (1976) "fusion of horizons", where meaning is constructed through participant and researcher communication. Researcher comprehension and reflection brings together new insights regarding participant experiences over the course of this interaction (Sharkey, 2001). The following discussion of the major identified themes will be carried out in front of a backdrop provided by

Herman's (1997) stage model of trauma recovery, the empirical literature of trauma, and the literature related to tattooing provided in Chapter Two. The findings of this study demonstrate that survivors use tattoos to engage in processes supportive of contemporary theories of trauma recovery while offering confirmation of conceptual ideas in the literature regarding their psychological significance. Not only do all the identified themes support the stages postulated by Herman, but the progression of experience in these participants also appears to unfold in a parallel way relative to her model. For example, the essence discussed in the last chapter seems to move from safety, to processing, and then into reconnection, as do the major themes associated with tattoo acquisition in these participants. An example of this progression, and an illustration connecting study themes to Herman's recovery stages is provided in Figure 3.

Thoughtful, Expressive Act

This first major finding of this study directly related to the decision-making involved in participant tattoo acquisition. People get tattoos for a variety of reasons, and the expression is one carried out in widely varying ways in terms of the amount of consideration involved. Some will get a tattoo on an initial outing to a tattoo shop with their friends and simply pick something off the wall that appeals to them in some way. Others take considerable time. Sweetman (1999) noted the process is often one of careful negotiation and collaboration, using the body as a means for expressing oneself.

During my bracketing interview at the onset of this study, an assumption of mine was that people take time to consider their tattoos. As with all aspects of the interviewing, I was careful not to introduce this idea to participants. I phrased a prompt in broad terms, "tell me about your decision to get a tattoo." Each participant took considerable time to evaluate and decide. In some cases, the thought process took years. This consideration involved collaboration with artists or

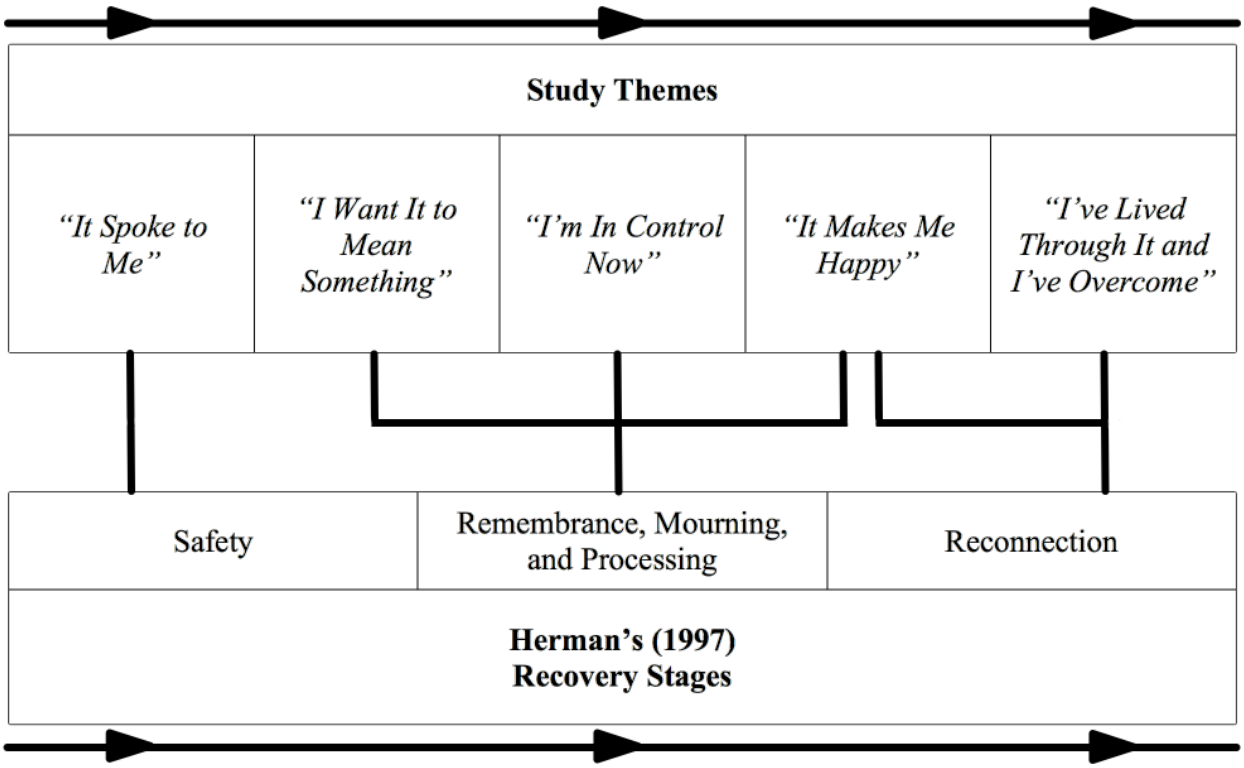

Figure 3. *Study Themes Connection to Herman's (1997) Trauma Recovery Model*

others to make sure it was just right. And the expression seemed to be one that was *needed* for each of them. Interestingly, and unprompted, the participants who had other tattoos emphasized that the one they got representing the trauma experience, was "different" from the others. For them, this chosen form of expression helped to do what was suggested by Atkinson (2003) and other researchers; provide a way to express their unique story of life events. This expression also has relevancy in terms of trauma recovery.

Safety is the first stage in Herman's (1997) recovery model. Trauma survivors in the early stages of recovery need to gain a sense of stability. Information presented in Chapter Two concerning this stage was discussed within a therapeutic context. Some of these participants talked about involvement in counseling but this was not true of them all, nor was it a focus of our interactions. While the impact of any therapeutic relationship did not enter the conversation in a significant way, the process of tattoo consideration and expression appeared to support Herman's first stage. In each case, the participants discussed disruption, and engagement in a range of ineffective coping strategies for a period following the event(s). The process of tattoo acquisition seemed to be a starting point for positive coping, and of stability.

Meaning Construction

In addition to being an expressive act, tattoo acquisition was imbued with meaning and symbolism. There was a universal consensus among these participants that the trauma *had* to mean or symbolize something in relation to their experience. And like the above, participants noted that this need to have meaning was different than their thinking regarding other non-connected tattoos. One participant remarked about not wanting it to be something off the wall, as she needed it to be about *her* unique meaning.

I believe the meaning and symbolism associated with the acquired tattoos represents an important aspect of the processing discussed by Herman (1997). Given the initial disruption that is common among trauma survivors (Lewis, 1996), the sense of brokenness they discussed, there was a failure to integrate the experiences; a critical, functional step noted by Herman (1997). Participants in many cases engaged in avoidance and alluded to this denial by their description of inappropriate behaviors and coping attempts. The process of assigning meaning and symbolism during the tattoo acquisition process seemed to allow participants to do the work necessary for a return to effective functioning. In short, they were using the act and associated symbolism to process events. Participants were finally given the opportunity to reflect on their experiences and construct new, individual meanings. Participants emphasized the meanings of their tattoos and how they are a part of understanding imperfection and expectations. This is an important point as participants talked about a sense of being lost; a period of searching for the *why*. They all experienced turmoil as they questioned why they had been subjected to certain events, and the meaning behind them. Jamie provided an example of this.

> You look for signs everywhere you go. You look for reasons. People talk about pennies or they'll talk about seeing things or birds or something like that. I was constantly looking for signs, but could never find any. I visited the grave a lot. I was glad for that, and took my son there because that was a memorial for him, but I never could get the answers spiritually that I wanted.

Tattoo acquisition became the form on which participants began to understand and answer these existential questions.

DeMello (2000) suggested that tattoos help the bearer express meanings in unique, individual ways. Sarnecki (2001) further talked of using symbolism in tattoos as a means for

working through the trauma, and ultimately incorporating the experience back into the self. These notions further support the ideas of Herman (1997) regarding the need to process. Tattoo acquisition represented one of the first successful strategies for these participants that allowed for the processing in which they needed to engage. The tattoo represented a reference point in trying to move forward in life. Once these participants could make sense of what happened, they were able to do so in a new way, changed, but no longer defined by what had happened to them.

Reclamation of Control

Loss of control is at the heart of the response related to a traumatic event (Herman, 1997). The participants of this study all conveyed the sudden, unexpected nature of the events they experienced. The complete loss of control during trauma translates into disruption and a sense of helplessness. The importance of this fact is acknowledged within a therapeutic context, as one important function of a counselor is to help the survivor reclaim a sense of control (Dass-Brailsford, 2007; Hopper et al., 2010).

In this study, participants all directly noted that tattoo acquisition was an act that helped them to begin regaining control over their lives. For example, one participant spoke directly about regaining control in a global sense. For another, it was about coming to grips with the realization that her body cannot sustain life. And for another, it was about taking control of the body that was the site of her traumatic abuse. In all cases, the use of the tattoo to modify or create how they reveal their stories to the world was a clear marker of control reclamation. Having the tattoo empowered them with a sense of being the director of their stories, rather than a reactor.

This reclamation of control is congruent with all three stages of Herman's recovery model. For example, a survivor regaining control was emphasized by Herman (1997) as

necessary for initial stability and could be explained as both a component of and outcome of the processing that Herman emphasized during stage two. This regaining of control helped participants process the events in a way that replaced previous struggles to do so. Participants' experience of taking control over their story may be viewed as falling within stage two processing and as extending into stage three. For Herman (1997), the third stage involved reconnection, with self and others. One participant specifically alluded to this as she discussed the increased control she felt and how the tattoo helped her communicate the story to others, something she avoided previously. So, the control over story helped facilitate reconnection with others by way of no longer avoiding it, modifying the telling, and/or making its telling easier.

This need for reclaiming control is discussed in the tattoo literature as well. Rohrer (2007) suggested that tattoos may serve this purpose, as did Sarnecki (2001), who observed that the process of getting a tattoo may help the bearer understand what has happened to them, and begin moving forward. These notions are congruent with the ideas expressed by Herman (1997) as necessary for successful recovery. For these participants, tattoos did appear to become an entry point for effective processing and a return to control over themselves and their stories.

Calming Comfort

A central question of this study explored the positive impact of tattoo acquisition. All the participants talked of their struggles following the trauma event(s). Some engaged in overspending, others in promiscuous behavior, and others tried to bury it and avoid thinking of it all together. This ineffective coping further contributed to their sense of feeling trapped and broken. All described tattoo acquisition as the point where this started to change.

Several discussed that the tattoos' presence, imbued with their personal meanings, made them feel better. They noted feeling happy, hopeful, and comforted by their tattoos. While there

is limited research available on memorial tattooing, the facilitation of remembrance appears to be helpful for recipients (Acharya, 2013; Davidson, 2016). For these participants, tattoos represented a permanent reminder of what has been endured, while providing a convenient, always available space on which to continue processing their experiences.

This provision is again supportive of Herman's (1997) model. In addition to processing, she emphasized the need for remembrance and mourning as essential tasks during stage two. Through this reflection, memories of the event are reprocessed, reconstructed, and put into a form to be reintegrated (Lewis, 1996; Menselsohn et al., 2011). In short, learning took place in these participants. And this learning had a positive impact, even though it sometimes sat outside full awareness, as alluded to by a participant's comments about not being able to fully "explain" her tattoo's impact.

Precipitator of Growth

Within a therapeutic context, the goal of treatment is to help the trauma survivor process events, learn to cope effectively, and reclaim their previous level of functioning. A recent trend in the literature looks beyond this basic work and suggests that trauma survivors may experience growth or even transformation when they successfully resolve their disruptive experiences (Calhoun & Tedeschi, 2013; van Dernoot & Burk; 2009). This idea is akin to maxims such as *what doesn't kill you, makes you stronger* or *a broken bone heals stronger at the break*. Yet, research in this area is limited, making it difficult to draw firm conclusions (Dekel et al., 2012). These participants did experience growth. In some cases, the tattoo was a representation for acceptance, leading to a changed perspective regarding a general approach to life. Examples of this could be seen in participant stories when they spoke of an increased tolerance for uncertainty, perspectives that are more global in nature, increased personal awareness,

approaching new people and situations with less fear, becoming more introspective, and possessing greater resolve. These changes are indicative of behaviors and thoughtfulness beyond what was previously known.

These changes and new perspectives are supportive of Herman's third stage as they all represent a new reconnection with and understanding of self, along with reconnection to others as insights and confidence are gained. The changes seen in participants are congruent with those suggested in Chapter Two as indicative of needed outcomes of this stage: a new understanding of normalcy, relationships, and boundaries (Lewis, 1996; Menselsohn et al., 2011). They are also supportive of DeMello's (2000) ideas about tattoos meeting the needs of the bearer, as well as, Atkinson's (2003) recognition of them as an expression of individual growth. It appears to be very much a case of etching new meanings and updated identity into the skin for these participants. This updated self is then communicated to others.

Hernandez-Wolfe et al. (2015) suggested that trauma experiences can help us understand how people manage overwhelming life challenges. In the case of these participants, not only were they able to regain lost functioning, but were also able to learn and gain tools for an increased ability to approach life. They all exhibited a greater understanding of themselves and a confidence about moving forward while facing new challenges. This insight into the significance of tattoos for trauma survivors warrants new considerations on the part of counselors as they work with the trauma population, counselor educators as they train students, and even tattoo artists who want an increased awareness regarding the importance of their work with such clients.

Limitations

All scientific research should be considered tentative, as new findings update, revise, or replace current understandings. This is especially true of phenomenological studies as one investigates what is becoming, thus never allowing for findings to be *final* (Vagle, 2014). What is happening and how participants make meaning of their world and experiences was a central feature of this study by design. It was naturalistic and exploratory in nature. This context frames the major limitation.

The purposeful sampling method used resulted in a sample of six Caucasian females. This homogenous group was not intentional. Effort was undertaken to reach a broad group within the study's inclusion criteria. This sample is simply not representative of the broader trauma survivor population. However, it is important to explore the research questions in depth and this sampling procedure did ensure that participants were appropriate for the study because they all had direct experience with the questions under investigation. And in this type of research, it is understood that generalizability of the findings if usually not possible.

It should also be noted that trauma was viewed very broadly in the study. It was left up to participants to determine if they considered their event(s) to be traumatic. This was in recognition that a traumatic event for one person may not necessarily be traumatic for another. The goal was to acknowledge and accommodate unique experience. While participants detailed a range of trauma situations, some were not present. For example, war trauma or natural disasters, two common experiences discussed in the literature, are not represented in this study.

These limitations are related to the nature of doing this kind of work. However, Thomas and Pollio (2002) debated the assertion that qualitative results are of limited generalizability and suggested that the usefulness of findings should be left to the clinical judgement of those using

the research. Furthermore, it is hoped these findings will lead to more focused questions and opportunities for further investigations. In light of these limitations, implications of the current findings are discussed next as they relate to counseling and future research.

Implications

Quality research should contribute to our knowledge of a topic, improve practice, generate additional research, and/or empower (Tracy, 2010). It is hoped that this study produced findings of interest and usefulness to mental health practitioners, particularly those working with survivors of psychological trauma and those seeking insight into related treatment strategies. As detailed above, the results of this study suggest the act of tattoo acquisition to be a beneficial one for trauma survivors. All participants discussed the variety of ways their recovery was positively impacted by their tattoos. Furthermore, the processes they outlined closely corresponded to the tasks necessary for successful recovery as presented by Herman (1997). Additionally, the information they provided lends support for the role of tattoos as discussed in the current empirical, and especially, conceptual tattoo literature. Given the ubiquity of trauma, the fact that counselors in all settings will be exposed to survivors, along with the practice of tattooing becoming a more popular practice, one that is demonstrated to be deeply meaningful, the need for understanding the process becomes clear. The implications of these findings are now discussed within the context of counseling practice and education.

Counseling Practitioners

Our work as counselors is focused foremost on the welfare of our clients. The provision of effective care that meets this standard requires attention to several factors including training, knowledge, skills, competence, etc. (ACA, 2014). Counselor training is addressed in the next section, but the need to become educated in trauma is clear. Trauma is complex and varied, and

effective work to address its impact requires the ability to understand and work with unique circumstances and responses. In the face of complexities related to trauma we should always be asking ourselves what we can do to best assist our clients.

First, we must work to reduce stigma. Not only may trauma itself carry stigma, as discussed in Chapter Two, but so to may the act of getting a tattoo. Kang and Jones (2007) observed, "…the tattoo's messages are limited by misinformation and the stigma that still attaches to tattooed people" (p. 47). The participants of this study were well aware of objections that still manifest within society. As counselors, we do a disservice to our clients if we subscribe to similar attitudes. Tattoos must be viewed as a respectable practice among the range of normal human behaviors, and as one that may have therapeutic value for survivors of trauma. Doing so will also help ensure we remain culturally relevant in a time when such practices are proliferating.

Current literature also discusses the need for continued exploration of effective coping. Garrido et al. (2015) were clear, "in a world that is dominated by news of conflict, violence and natural disasters affecting millions of people around the globe, there is a need for effective strategies for coping with trauma" (p.1). The need for effective strategies was made evident by participants as they discussed spending time following the trauma event engaged in counterproductive or even harmful activities. While I am not suggesting that counselors encourage clients to get tattoos as a coping strategy, if we have clients who have or are considering tattoo acquisition, we can evaluate what that means for them and how it may be used within their unique context. For example, counselors may consider where the practice falls relative to previously attempted coping strategies. Another focus could be the process each client goes through or how do they think it will help. Counselors may also explore examples of its

impact to date in clients who have already acquired a tattoo. Exploring these areas will help both the client and counselor understand the processes underway, and is consistent with Herman's (1997) suggestions regarding stability and processing.

These findings also have value within a therapeutic context relative to intervention strategies. Literature that support Herman's (1997) recovery model was discussed in Chapter Two. A wide range of possibilities exist for clinicians working with trauma survivors, in terms of integrating these findings into specific interventions. For example, in these participants, once they began reconstructing their trauma experience, they experienced an increased ability to move forward in a more adaptive way. Their experience echoed the process of cognitive approaches that include identification and examination of distorted cognitions along with deliberate challenge and modification of thoughts related to the trauma experience (Chard & Gilman, 2005; Humphrey, 2009; Makinson & Young, 2012). The basic implementation of this approach includes, 1) learning how our beliefs may lead to distressing consequences, 2) identification of beliefs that are problematic, 3) differentiation between realistic and self-defeating thought patterns, 4) disputing of dysfunctional beliefs and searching for alternatives, and 5) support as clients come to understand how thoughts maintain symptoms and work to shift toward more functional beliefs (Humphrey, 2009; Makinson & Young, 2012). Based on the findings above, client tattoos may be used to facilitate work on these points by focusing on their meaning, symbolism, and the client's changing perceptions. Counselors could actively use client tattoos as a jumping off point for reflection and discussion regarding goals related to cognitive processes, and facilitation of changes desired by clients. Such work is consistent with stage two processing (Herman, 1997), and provides counselors with an activity that may be more amenable to clients

than, or used in concert with, traditional thought tracking and recording. It provides an additional tool that may be useful in specific situations, with specific clients.

Another option stems from Neimeyer's (1999) work, who argued that traditional grief theories are ill-prepared to address the complex realities facing survivors of trauma. Because of significant changes to peoples' stories, a process of meaning reconstruction is necessary. Not only is this congruent with Herman's (1997) stated task needs, it is consistent with participants of this study in the way they described the meaning and symbolism they considered in their tattoos. Such a position emphasizes the uniqueness of a person's experience over theories focusing on common experiences, a major criticism of the PTSD literature. Traumatic events may lead to hopelessness by disconnecting survivors from their preferred stories. In a sense, survivors may lose their voice.

Counseling approaches focused on narratives with trauma survivors not only foster meaning-making around the event(s), but encourages agency and choice (Beaudoin, 2005). This work offers the client an opportunity to articulate and understand what has occurred, thereby increasing a client's confidence and choices regarding life direction (Beaudoin, 2005; Carey, 2013). Counselors using this approach can help clients reflect on life assumptions and how the traumatic event has impacted those assumptions while working to frame meaning moving forward as experiences are reintegrated (Neimeyer, 1999). Ultimately, survivors are provided the means to construct, edit, and re-author their personal stories. Choice, being given a voice, a regaining of confidence, and reflection were all discussed by participants as being facilitated by tattoo acquisition. And it was evident that their stories had become more personal following the act. Study participant tattoo acquisition helped them take control of their stories. It also provided

a way to communicate them. Trauma survivors have a need to develop a coherent narrative in the aftermath of events, and using tattoos may be one way to do so.

Effective counseling allows for this narrative to develop, and narrative specific approaches further encourage the development of explanations within an overall story (Briere & Scott, 2015). Participants conveyed the process of imbuing the event(s) with personal meaning and overall life context as they discussed the impact of their tattoos. Trauma no longer defines them. When working with clients, counselors must remain mindful that client stories may contain inaccuracies. However, Herman (1997) herself acknowledged that the process is a reconstruction, with potentially significant gaps, that is never fully completed. The benefit comes through clients retaking control of their stories and creating new meanings. Counselors may take advantage of and use client tattoo work in session to explore and help facilitate insight. Furthermore, counselors willing to incorporate tattoo discussions in their work acknowledge respect for and understanding of clients, likely beneficial to the therapeutic alliance and the sense of stability so important for survivors.

Finally**,** while the status of tattoo acquisition as a form of expressive art may be debated, it was shown in this study that the act of getting one was certainly an expressive act for the participants. Expression was demonstrated by the time participants took to thoughtfully consider their decision, placement choices on their bodies, and their sense of *needing* to engage in the act. Additionally, the collaboration they discussed indicated personal involvement during the act of creation. There is an activity sometimes used in counseling settings where the individual must create a tattoo. During the activity, the person is instructed to consider purpose and meaning relative to creating the piece. A similar thing may be done with tattoo bearers, only after the fact. These participants described being engaged in a highly expressive act. Counselors may still be

able to discuss what this process was like for them, in addition to related meaning and symbolism. This may be one of the few ways survivors are able to convey their experience in a manner that is palatable. Participants of this study spoke of their stories becoming easier to tell following their tattoo acquisition. I would argue that consideration of this practice is important even for counselors not inclined toward the expressive arts. It is known, "…processes of healing in clinical interventions include narrating suppressed or inchoate experience to give it form, experiencing the empathic witnessing and understanding of an other…" (Kirmayer et al., 2014, p. 312). Regardless of theoretical orientation, counselors working with clients who have acquired a tattoo may use that work as a means for helping clients explore and gain insight. This idea is consistent with the tattoo literature that suggests they may help facilitate expression of experience. Not only did tattoos make telling the story easier, participants spoke of now telling their stories more completely. By leveraging tattoos as an expressive act, counselors can use them for processing, and as an additional means to broaden understanding as they assist clients to navigate trauma recovery.

Based on these participants, tattoos may illustrate a new way to help clients access and process trauma material that may have been too difficult to discuss in the past. This is important as processing of trauma experiences are critical to successful recovery. Tattoos not only allowed participants to communicate their stories, but the act encouraged processes consistent with those discussed in Herman's (1997) recovery model. These findings encourage counselors to regard trauma survivor tattoos in a unique way not previously considered in the field. Their potential to act as a conduit for working with client cognitions, narratives, and expressions make them a potentially important part of the counseling process.

Counselor Educators

A major issue for mental health, relative to this discussion, involves the training of counselors and other mental health professionals prepared to serve trauma survivors (Courtois & Gold, 2009; Webber et al., 2006). Webber et al. (2006) asserted, "all counselors should be competent in basic trauma knowledge and response" (p. 19). Yet, in one study of 369 counselors examining grief training, researchers found more than half of the participants reported no course preparation and limited overall understanding of meaning-making theories. They also underscored a lack of standards regarding available training (Ober, Granello, & Wheaton, 2012). The *Council for Accreditation of Counseling & Related Standards* (CACREP) introduced trauma into the 2009 standards that advised the need to understand crisis, disasters, and trauma causing events (CACREP, 2008). While gains have been made, trauma is generally marginalized and still not considered as a core focus in most graduate training programs (Courtois & Gold, 2009).

Limited research is available regarding the standardization of trauma training (Ober et al., 2012). However, several suggestions may be made based on these current findings. Counselor educators should incorporate trauma information and theories into coursework. Evidence exists that trauma focused approaches are more effective than supportive approaches alone (Kar, 2011; Tran & Gregor, 2016). Specific to the outcome of this study, counselor educators may prepare students for this work by covering meaning-making theories and discussing them within the context of trauma. Awareness also needs to be built regarding this population, and how tattoos or other expressive forms, not only aid survivors, but also help us gain access to stories and meaning as we work with them. Practical issues also need to be discussed. For example, how do we find out about a tattoo in the first place if not visible? A single question on a screening form

such as, “Do you have any tattoos connected to life events?”, might serve as an entry point to the rich world of meaning described by these participants.

The results of this study contribute new knowledge to our understanding of the association between tattoos and psychological trauma. For study participants, the act of getting a tattoo was expressive, healing, and positive. These findings demand that greater attention be placed on the significance of this form of body modification. As such, these recommendations call for fostering increased technical and cultural competence relative to working with trauma populations.

Recommendations for Future Research

The findings of this study offer a variety of different directions to take in future research. Continued investigations in this area should contribute to the conversation about trauma and how we best help survivors. Focused research will also help to develop best practices regarding the implications discussed above. It is incumbent on us as counselors to encourage such work in the interest of providing the best service to our clients. This may be achieved in several ways.

First, this study has the potential to effect positive social change by encouraging movement of the act of tattooing away from deviant discourse. Bias exists in the research history of tattooing as discussed previously. Consistent with social attitudes, tattooed individuals have been disenfranchised through stigma and an association with deviance. All study participants spoke of stigma, yet they also noted the positive experience they received from others afterwards. A participant remarked that it moved the conversation from a negative focus. While participant mental health or personality was not evaluated in this study, the overwhelming consensus of participants reflected an act that was deeply meaningful and helpful to then during their trauma aftermath. It also represented one of the first positive steps they took regarding

control. Given the prevalence of trauma, and the practice of tattooing in modern society, we only undercut our knowledge of important processes that may help us understand and be more effective facilitators of trauma recovery. Researchers are urged to investigate the psychological meaning of tattoo acquisition. Doing so will help establish their legitimacy as a social science research topic, and shed additional light on the role they play in overall mental health.

The participants of this study described a wide range of consequences that stemmed from their trauma experience. Interestingly, only one described their experience in terms of PTSD. While this study did not focus on features related to formal diagnosis, the range of experiences for participants were wide, not necessarily fitting the diagnostic criteria for PTSD. Nevertheless, the experiences were highly disruptive to their lives. The reality for these participants coincides with criticism in recent literature pointing to an overreliance on PTSD to explain the trauma response, and supports expert consensus that more research is needed to examine the totality of the survivor experience. The second recommendation is to focus research on the full spectrum of trauma response. Doing so will increase our understanding of survivors to better meet their recovery needs.

The third recommendation stems, in part, from the primary limitation of the current study. Future investigations should strive to include a broader population of survivors relative to race, gender identity, and other factors. Additionally, research examining the role of tattoo acquisition as related to other trauma types and populations is also needed. For example, participants in this study who experienced direct violations to their body, discussed reclamation of control in relationship to their physical bodies. Studies that are more diverse, or projects targeted on specific types and populations, will help tease out nuances and differences relative to trauma type and individual experience. So, several possible directions where spurred by this

investigation. Researchers might examine to what extent tattoos influence or direct *behavior* after acquisition. Or the experiences of survivors of other types of trauma, such as war violence or natural disasters might be investigated. Effort could be focused on tattoo placement decisions and difference relative to trauma type. Research such as this will open a door to understanding that has been held shut for decades.

Finally, information would be helpful regarding the effectiveness of tattoos versus other trauma treatments and healing efforts. The use of rituals and ceremonies in response to trauma is discussed in the literature (Johnson, Feldman, Lubin, & Southwick, 1995). The practice of tattoo acquisition seemed to be a helpful one in the face of other failed coping attempts by participants in this study. Implementation of comparison studies will help further determine distinctions and effectiveness relative to other rituals and the common therapeutic approaches discussed above. Understanding how this practice is different from others, will be critical to its usefulness in counseling. Counselors are charged with building the competence needed to be effective within the context of a pluralistic society. Further investigations that support these recommendations may help provide the information needed to do our best work with this and similar populations.

Conclusion

The experiences of the participants in this study support the use of tattoos by trauma survivors as a positive coping mechanism; one that seemingly provides several benefits. This study also underscores the need for increased understanding relative to such practices, as does social activity. At the time of this writing, there were over 200 occurrences of mass shootings in the United States alone during the first half of the year (Mass Shooter Tracker, 2017). Occurrences of psychological trauma exposure is an unending, somber reality for mental health practitioners. And another article appeared recently in the popular press about women who used

tattoos to help heal and reclaim their bodies in the aftermath of sexual assault. The expressive process of getting a tattoo was discussed as facilitating strength, empowerment, symbolism, changed perspectives, and reclamation of the body among those interviewed (Thomas, 2017). Accounts such as these connecting tattooing with trauma are abundant, yet the topic remains largely ignored in the scientific literature. We are far removed from a time where professionals viewed this practice as the province of "prostitutes and perverts" (Parry, 1934, p. 476). And it is time for this reality to be reflected in our work.

Our human bodies serve to anchor us to the physical world. They bring together the constellation of organs that provide and sustain life, act as receivers and senders of information, and allow us the ability to interact with others. They center our place in space and provide the collective means for helping us to understand who we are. Disruption or threats to this system may alter self-understanding in fundamental ways. For the bearer, tattoos provide a permanent, on the body, in the flesh marker. A marker that may be used for reflection, processing, and redefinition of life experience. A marker that is also at the ready to help calm and tell the story. Sanders and Vail (2008) suggested the act of tattooing shapes identity, helps define the self, and are "...symbols of what [people] see themselves to be" (p. 61).

Much like the phenomenological interviewing used in this study, counselors rely on stories to enter the client's world. Such empathetic engagement, along with knowledge and skill, becomes the means through which we help facilitate desired or needed change. For counselors, tattoos act as another vehicle we may use for a portion of this journey, particularly in cases where the pathway has become obscured or difficult to traverse as the result of unspeakable experiences. Increased knowledge of the utility tattoos may hold for our work alone make investigations of the topic worthwhile.

In *The Body Keeps the Score*, trauma researcher van der Kolk (2014) noted that many approaches are available for working with trauma, but it imperative that we pay attention to individual experience. It is hoped this research will contribute to the trauma knowledge base and help mental health practitioners further understand the trauma recovery process and develop new ways for working with unique client circumstances in the quest to help manage human suffering in the aftermath of life changing events. Participants proudly talked of what they had endured, and overcome. And Kay spoke of the way her tattoo acquisition led to a managed recovery.

> I can move on. I can take what happened to me and make something good out of it. I don't know what that is yet, but I'm hopeful. You know, maybe that will mean spending more time with my nieces. Maybe that will mean helping another family. Maybe that will mean we'll travel. I don't know. We're just going to wait and see what happens, but I can't dwell on that anymore …When I cry now it's not really that I'm sad. It is those things like, I know they're [her children] watching over me. That makes me happy so I cry. I wonder what they would have been like had they lived. I picture it and that kind of makes me happy just to have that in my mind, so I cry.

So, the journey is not yet complete. She noted abandonment issues that remain unresolved. And others also mentioned the work that lies ahead for them. However, they are now able to more fully and actively address this work.

During a discussion with the phenomenology research group, a member mentioned that my themes reminded her of the Japanese art *kintsugi*. It involves repairing broken pottery with a mixture of powdered gold and lacquer resin. Proper technique produces a piece that is whole and functional again, while the previous damage remains intentionally visible as an important aspect of the object's overall story and beauty (Kwan, 2012). Like the history of such objects, tattooing

for these participants helped them take control of and embrace their experience. While previously shattered, and though scars remain, they are each on a journey toward their own unique restoration…one where trauma forever changes them, but no longer defines them. For all of them, tattoo acquisition had a profound facilitative impact, fostering a move from a state of brokenness to one of evolving wholeness.

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Appendices

Appendix A: Study Flier

How Are Your Tattoos Connected to Your Traumatic Experience?

Trauma and Tattoos Research Study
I am a University of Tennessee counseling PhD student investigating the relationship of tattoos with emotional trauma. I want to understand what tattoos mean to those who get them as the result of a traumatic experience. Participation will involve one 60-90 minute interview and a brief follow-up at the conclusion of the study. Your identity will remain confidential.

Participation
To participate you must, 1) have experienced an event you consider traumatic, 2) have obtained a tattoo related to that experience, 3) be over 18 years in age, and 4) be at least twelve months past the traumatic event. Participants will receive a $15 Visa gift card.

To participate, please contact:
Everett Painter at 865-235-7200 or epainte2@vols.utk.edu

Everett Painter
epainte2@vols.utk.edu

Appendix B: Informed Consent Statement

Therapeutic Aspects of Tattoo Acquisition: A Phenomenological Inquiry into the Connection Between Psychological Trauma and the Writing of Stories into Flesh

Introduction

My name is Everett Painter. I am inviting you to participate in a dissertation research study for the completion of my doctoral work in Counselor Education at the University of Tennessee.

The purpose of this study is to explore, describe, interpret, and understand the lived experience of trauma survivors who obtained a tattoo in connection to their trauma experience(s). I want to understand the meanings held and properties they may possess for survivors of traumatic events.

Information About Participants' Involvement in the Study

I will interview you about your trauma experience(s), acquisition of tattoos, and how these two things are connected. I will meet with you for one 60-90 minute interview. I will ask you to consent to recording of the interview as the narrative developed will become the data analyzed. Interviews will be transcribed and used to build descriptions, themes, and interpretations regarding your experience. Selected transcripts, with all identifiers removed, will be taken to an on-campus research group which focuses on research rigor and process. These transcripts are read by group members and analysis suggestions are provided by the members. Members of the group sign a confidentiality agreement prohibiting discussion of the interview content outside of the group. Sharing transcripts with this group helps increase the rigor and validity of the research analysis process. Following initial analysis of interview transcripts, I will send my findings to you for feedback and to check for accuracy regarding your experience. At the completion of the study, you will be provided information on how to access the results, if you choose. I may contact you for clarification purposes during the study.

Potential Risks

Confidentiality will be protected as far as possible, but cannot be absolutely guaranteed. Additionally, it is possible that discussing and reflecting on life experiences such as traumatic events may result in the occurrence of strong feelings and emotions. I will minimize this risk by monitoring for signs of distress during your participation and by allowing you to withdraw from the study at any time without penalty. Should you encounter any participation related distress, I will refer you to a local counseling resource. I will provide all participants with a list of local mental health service providers.

Potential Benefits

Your participation in this study will help me explore, describe, interpret, and understand your experiences related to getting a tattoo connected to traumatic events. These findings will contribute to the existing body of knowledge related to topics such as trauma coping, tattoo

meaning, and counseling interventions with trauma survivors. Such understanding may impact counselor training and practitioner intervention strategies. There is also potential benefit to you in the form of increased insight and understanding relative to life experiences. Results may provide a benefit to society at large through increased understanding related to recovery from the common occurrence of psychological trauma.

Compensation

You will receive a $15 Visa gift card for your participation. You are eligible for this gift card even if you withdraw from the study prior to its completion.

Confidentiality

I will keep information collected during this study confidential by using pseudonyms assigned to you along with the removal of any identifying information during interview transcription. Audio recordings will be immediately downloaded (and saved to a secure file accessible by only the researcher) following interviews and erased from the recording device. All data will be stored securely in password protected files on a secure computer and will be made available only to persons conducting this study unless you specifically give permission in writing to do otherwise. No reference will be made in oral or written reports which could link you to this study.

Contact Information

If you have questions at any time about the study or the procedures (or experience adverse effects because of participating in this study), please contact the principal investigator, Everett Painter, at epainte2@vols.utk.edu and 865-235-7200 or his advisor, Dr. Melinda Gibbons, at mgibbon2@utk.edu. If you have questions about your rights, please contact the University of Tennessee IRB Compliance Officer at utkirb@utk.edu or (865) 974-7697.

Participation

Your participation in this study is voluntary. You may decline to continue without penalty and without loss of benefits to which otherwise entitled. If you withdraw from the study before data collection is completed, your data will be destroyed and will not be used for analysis.

Participant's Consent

I have read the above information and received a copy of this form. I agree to participate in this study and declare that I am at least 18 years of age.

Participant’s Name (printed): _____
Participant’s Signature: _____
Date: _____

Appendix C: Interview Protocol

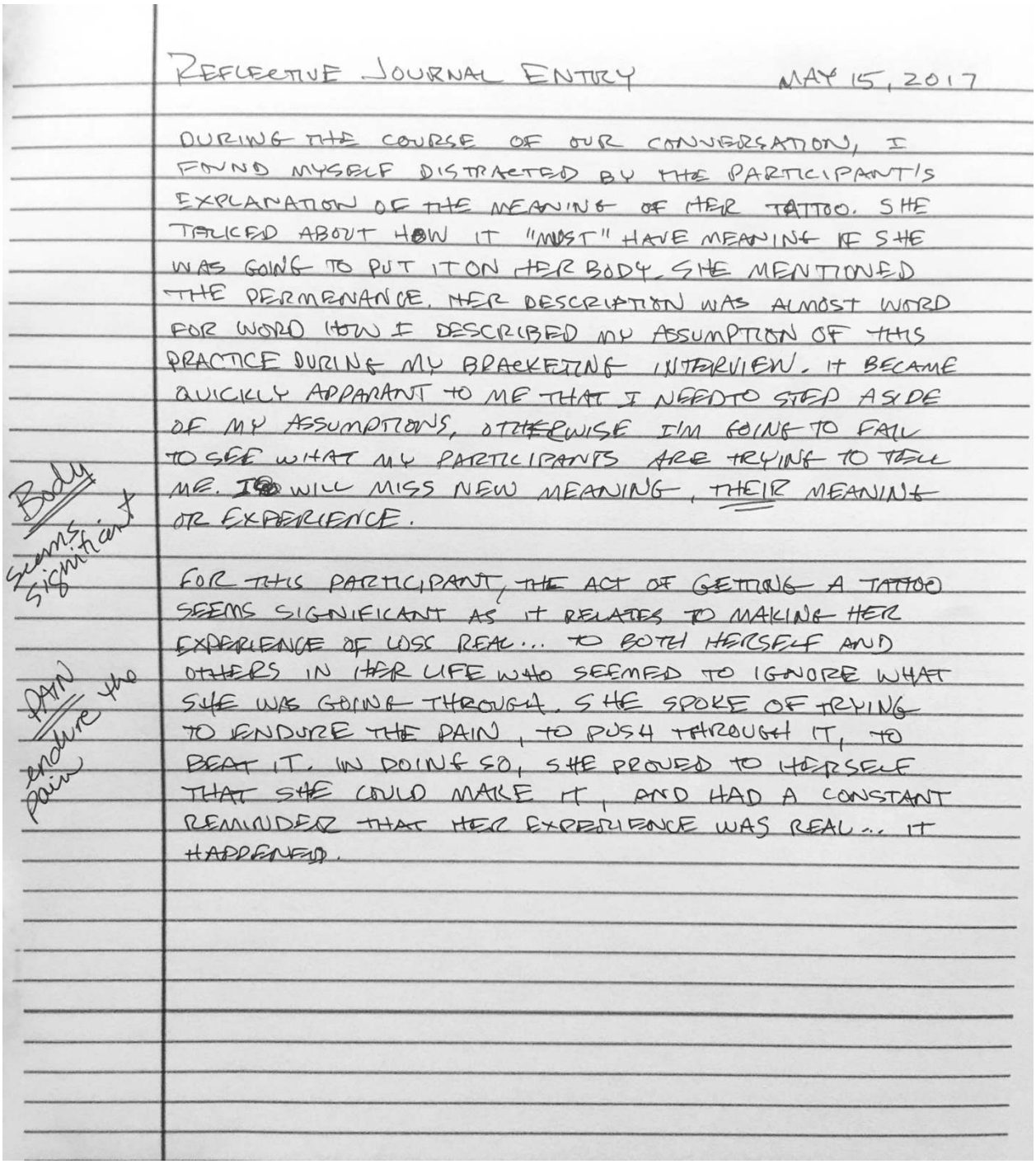
Interviews for this study are phenomenologically based therefore will be open-ended and intentionally broad so participants are not led by researcher assumptions and to allow for wide, descriptive responses from the participants. The primary questions used will include:

Q1: Tell me about your trauma experience.
Q2: Tell me about obtaining your tattoo(s).
Q3: Tell me about the ways in which those two things are connected.

Further prompts will be similarly broad based on participant responses and used to encourage elaboration. These probes will be drawn from the following:

1. Tell me more about...
2. Could you give me an example of…
3. I'm not quite sure I understood…Could you tell me more about that?
4. I'm not certain what you mean by…Could you give me some examples?
5. Could you tell me more about your thinking on that?
6. You mentioned...Could you tell me more about that? What stands out in your mind about that?
7. This is what I thought I heard…Did I understand you correctly?
8. So, what I hear you saying is…
9. What makes you feel that way?
10. What are some of your reasons for…
11. You just told me about…I'd also like to know about…

Appendix D: Reflective Journal Sample



REFLECTIVE JOURNAL ENTRY MAY 15, 2017

DURING THE COURSE OF OUR CONVERSATION, I FOUND MYSELF DISTRACTED BY THE PARTICIPANT'S EXPLANATION OF THE MEANING OF HER TATTOO. SHE TALKED ABOUT HOW IT "MUST" HAVE MEANING IF SHE WAS GOING TO PUT IT ON HER BODY. SHE MENTIONED THE PERMENANCE. HER DESCRIPTION WAS ALMOST WORD FOR WORD HOW I DESCRIBED MY ASSUMPTION OF THIS PRACTICE DURING MY BRACKETING INTERVIEW. IT BECAME QUICKLY APPARANT TO ME THAT I NEED TO STEP ASIDE OF MY ASSUMPTIONS, OTHERWISE I'M GOING TO FAIL TO SEE WHAT MY PARTICIPANTS ARE TRYING TO TELL ME. I WILL MISS NEW MEANING, THEIR MEANING OR EXPERIENCE.

Body seems significant

FOR THIS PARTICIPANT, THE ACT OF GETTING A TATTOO SEEMS SIGNIFICANT AS IT RELATES TO MAKING HER EXPERIENCE OF LOSS REAL... TO BOTH HERSELF AND OTHERS IN HER LIFE WHO SEEMED TO IGNORE WHAT SHE WAS GOING THROUGH. SHE SPOKE OF TRYING TO ENDURE THE PAIN, TO PUSH THROUGH IT, TO BEAT IT. IN DOING SO, SHE PROVED TO HERSELF THAT SHE COULD MAKE IT, AND HAD A CONSTANT REMINDER THAT HER EXPERIENCE WAS REAL... IT HAPPENED.

Pain / endure the pain

Appendix E: Code List Example

Researcher and In-Vivo Coding (initial) – Interview 1

body	shame +	"It calms me"
loss +	"I couldn't do what I was	not forgetting
"first miscarriage"	supposed to"	important people remain
uncertainty +	defective	present +
privacy +	unfairness	"cathartic experience"
"a lot of blood" +	search for a reason why +	conquer the pain
"afraid"	"crisis of faith"	growth +
surprise	lack of empathy	"worst I felt"
alone +	"take that pain" +	"they're part of me"
lack of concern +	symbolic +	fills a void
sudden	expression	provides a connection
unexpected	body placement +	unavailable previously
support	emotional	"broken heart"
detachment +	"always be in my heart"	"ready to move on"
"expectation"	replace pain with hope	sad to happy/resolved
expectation unfulfilled +	comfort +	"can't dwell anymore"
"feel like a disappointment"	perspective +	"my way of coping"
fear +	"shows they were here"	positive coping
hope	memorial/remembrance +	"I didn't want them to be
reality	to make real	ignored anymore"
"felt I was going to die"	validation	"we're dealing"
health	meaning +	"and this is part of it"
"life coming out of me"	stigma	
"I felt abandoned"	took time	
"they are not coming"	consideration +	
"rock" +	"for the longest time"	
"didn't want to feel that	"wanted it to mean	
again"	something"	
loss of respect	"that I identified with"	
"I had to grow up"	identity	
abandoned	representation	
cope +	meaning	
"losing my baby"	"acknowledging"	
"messed up my body"	story +	
acceptance +	"kind of shows"	
"broken" +	helps to tell the story	
"doesn't sustain life"	helps to process/understand	
violation	presence	
"wrong puzzle piece"	"I can look down everyday"	

+ denotes recurring unit

Vita

Everett Painter was born in Richmond, Virginia on September 2, 1971. He earned a Bachelor of Science degree in Psychology (with a minor in Sociology) and a Master of Science degree in Counseling and Human Development from Radford University. Professionally, he spent nine years serving at various colleges and universities across the country in student affairs. For the past nine, he served as a counselor in the higher education setting focusing on mental health and overall student development. He has experience as a clinical facilitator in a community agency addressing substance abuse, anger management, and at-risk families. He also completed several instructional experiences including five years as an adjunct psychology instructor. Clinically, he values the integration of humanistic, Adlerian, constructivist, and ecological perspectives. Everett has authored a variety of published works, contributed to two textbooks, and maintains a regular presenter schedule at state, regional, and national conferences. Professional service is important to him as demonstrated by his involvement with counseling organizations such as the American Counseling Association (ACA) and Chi Sigma Iota (CSI). Past accomplishments include winning ACA's graduate student essay competition in 2014, placing twice with his doctoral team in ACA's graduate student ethics competition, and selection as a CSI Leadership Intern. He was recently recognized for the University of Tennessee's Counselor Education Program's Most Outstanding Leadership, awarded a University of Tennessee Chancellor's Citation for Extraordinary Professional Promise, and selected as an Editorial Fellow for the Association for Counselor Education and Supervision's flagship professional journal. Everett will graduate with a Ph.D. in Counselor Education and begin serving as a tenure-track Assistant Professor of Counseling at Edinboro University of Pennsylvania in August 2017.