2023

College Experiences of Female Students With Posttraumatic Stress Disorder

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Walden University
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Abstract

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BSW, Lewis-Clark State College, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Higher Education: Leadership, Policy, and Change

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Abstract

This study, using feminist trauma theory as the conceptual framework, addressed a gap in the literature about female university students' experiences with posttraumatic stress disorder (PTSD) related to the academic and social supports needed for college success and degree completion. Nearly 30% of college students will drop out during their 1st year in school. Research suggests that personal histories of simple and complex traumas may be influential factors contributing to dropout rates. There are limited programs or resources in colleges and universities to address the needs of students struggling with past traumas aside from routine student counseling. The purpose of this basic qualitative study was to explore the experiences, beliefs, perceptions, attitudes, and needs of female college students with PTSD and what they identify will guide them toward successful graduation. Data were collected using an audio platform via semistructured interviews with nine participants who met the criteria of being female college students diagnosed with PTSD, complex PTSD, or a trauma-related diagnosis who had some treatment background. Data analysis included using a priori and open coding to identify codes, categories, and themes. Themes emerged on (a) personal resiliency and (b) trauma-informed staff, understanding, and communication. The findings may inform college stakeholders about the needs of college students with histories of trauma so that they may provide a trauma-informed environment to accommodate students of all backgrounds, thus reducing dropout rates and increasing student retention, overall health, and success.

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Dedication

I dedicate this study to all the strong women in my family, all of whom were unable to complete their high school degrees due to physical, sexual, financial, verbal, legal, religious, cultural, racial, and emotional traumas brought about and compounded by societal forces beyond their control; to my mother, who forfeited a dream for higher education to raise daughters she instilled with grit and tenacity; to my grandmothers, strong and fiercely independent, retaining dignity, while forging positive female presence in the environment of golf and entrepreneurship, and paving the way for Boomers, Millennials, GenXs, and GenZs; to all the women I have known, worked with, studied with, and mentored who shared vision for a kinder, fairer society in which all people have the opportunity to study, learn, excel in academia, and contribute to an equitable, wholesome, global community.

I dedicate this study to my late brother Marshall for teaching me the beauty of bravery and authenticity of expression during our formative years; to my late father, who taught me practical life lessons I didn't realize were so valuable until late in life; to my grown and growing child, for whom my love has no words to express adequately; and finally, to my ancestors and to God for blessing me with this version of life, the gift of motherhood, endless opportunities to practice courage, resiliency, love, curiosity, and the opportunity to share with others who possess greatness of mind, body, and spirit. My gratitude and love to all of you!

- Cleo

Acknowledgments

I am most grateful to Dr. Cathryn Walker, my committee chair, for her endless contribution and years of understanding and support during this process. I would like to thank my committee member Dr. Fran E. Reed for her focus on detail and excellence, as well as for her kindness and encouragement. I am grateful to my URR, Dr. Gelu Ionas and to Form and Style for providing grace and kindness when suggesting edits. My current and former student advisors, Dr. Chue Vang and Dr. Joshua Bass, the latter of whom supported me for the first part of my journey and the former of whom provided unequivocal support during the final years of this process. I am forever thankful to my initial committee chair, Dr. David L. Bearden, for his unwavering cheer, wisdom, and support. I am forever thankful to my child for trusting my parenting and for being supportive during difficult times; thank you for knowing that my love was unconditional. I am thankful to my family and friends for being themselves and for allowing me the space to make mistakes throughout this process, and to therapists and dear friends David and Linda Bash for their support during my most difficult times, and for showing up when I needed that. I am thankful to Air Force supervisors and Airmen who taught me invaluable lessons. I am thankful to the participants of this study for their courage, vulnerability, and willingness to share their experiences and be interviewed by a stranger. Always, I am thankful to our Creator.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Growing concern for college student retention in the United States has created a need to explore the reasons why students drop out of college. Currently, 32.9% of college students will drop out in their first year (Hanson, 2022). Although reasons for dropout vary, there is substantial literature that explores the possibility of both simple and complex traumas as influencing factors. Of the approximately 70% of Americans who are experiencing trauma, 20% will develop posttraumatic stress disorder (PTSD), 8% have been diagnosed with PTSD, and currently one out of 10 women develops PTSD as opposed to one out of 20 men (PTSD United, 2022). The National Center for PTSD has reported that despite the focus of research towards male combat veterans with PTSD, half of all U.S. American women will experience trauma in their lifetimes, with women experiencing PTSD at 2 or 3 times the rate of men (Valenstein-Mah et al., 2019). Primary reasons for a higher prevalence of PTSD symptoms in women are childhood sexual abuse, intimate partner abuse and rape, rigid social roles, and fewer resiliency supports (Valenstein-Mah et al., 2019).

Negative aspects of PTSD adversely affect college performance, both during and beyond the 1st year of college (Boyraz et al., 2017). PTSD has been linked to diminished executive functions, emotional effort regulations, substance abuse, 1st-year college dropout, social isolation, interpersonal problems, and avoidance of help-seeking behaviors due to mental health stigmas (Boyraz et al., 2017). These factors can create barriers to academic success (Boyraz et al., 2017). Furthermore, studies have recognized a gap in understanding the consequences of sleep deprivation associated with PTSD,

symptom recognition versus scholastic effort regulation, and the unique contributions of different trauma types as they pertain to clinical treatments and outcomes (American Psychological Association, 2023; Turner, 2010). Particularly relevant to the college-level teaching profession is the idea that by developing better ways of understanding challenges that students with PTSD encounter, colleges can develop adaptive methods to encourage and facilitate college success within this population (Boyraz et al., 2019).

Although national and state data exist regarding college retention and graduation rates in the United States, data about female graduates and female college retention are either lacking or, at best, vague. Most studies only record first-time, full-time traditional students, omitting an unknown population of part-time, nontraditional, and returning students. Of these students, women have not been counted or studied concerning their experiences in higher education, their resiliency, or their trauma histories, which may impact their educational journeys.

Background

Previous studies about PTSD and the rates of students diagnosed with PTSD provide information about poor outcomes in student retention after the 1st year of college as well as differences in how trauma is perceived by gender (Boyraz et al., 2017). There are gaps in research regarding presenting symptoms and available support for students during and after the 1st year of college (Boyraz et al., 2017). Sleep disturbances, dissociation, substance abuse, and avoidance behaviors affect academic performance and are common symptoms of PTSD and are thus relevant to feminist trauma theory (Boyraz et al., 2019).

Researchers have raised questions regarding making meaning and sense of trauma experiences, particularly with how women may adhere to and act out on the dominant culture's meaning of PTSD, and on educational leaders' immunity and resistance to change (Turner, 2010). Questions specific to women about making meaning and sense of these experiences include low external locus of control regarding academic success versus high internal locus of control when seeking assistance, compared to the opposite in their male counterparts (Morelli et al., 2021). Encouraging leaders to learn innovative ways to work with these challenges has the potential to create lasting and positive change in communities that have sustained significant traumas impacting educational outcomes (Mahlangu, 2020).

As previously mentioned, scarce data exist about female college retention rates in the United States, particularly regarding underserved and nontraditional student populations. Historically, data have been tracked about mainstream information related to traditional pathways toward higher education and career pathways, providing questionable accuracy about marginalized and compromised students.

Treatment models continue to develop as PTSD is further explored and becomes more prevalent globally due to natural and human disasters. Drug therapy, cognitive behavioral therapy (CBT), neurofeedback models, narrative, breathing, meditation, eye movement desensitization, reprocessing therapy (EMDR), and nature-based therapies are some treatments that have offered help, yet it is unknown whether they affect positive educational outcomes, specifically (see Spinazzola et al., 2018; Wallace et al., 2020).

Problem Statement

In this study, I addressed the gap in the literature about university female students' experiences with PTSD related to the academic and social supports needed for college success and degree completion. Little is known about college dropout rates resulting from PTSD for female university students. PTSD has been explored within the context of war and combat veterans, while trauma symptoms outside of these parameters have been treated as other diagnoses or not at all (Bisson Desrochers et al., 2016). Historically, female retention and dropout have been researched in the context of college in terms of ethnic or racial minority status, depression, family, and social barriers, which have been contributors to dropout rates for this population of students (Arbona et al., 2018). Consequently, there are few qualitative accounts of female university students with PTSD related to retention and completion and factors that may contribute to their college success.

PTSD traits are prevalent in 56–85% of college students (Yalch & Levendosky, 2019). Counseling centers are modeled to address these needs of students; however, they are not designed to provide support for female students with PTSD. Counseling services in university contexts focus on suicide prevention and other high-risk behaviors without filling the need for more moderate, preventative services that reduce mental health stigmas and encourage help-seeking behaviors before symptoms become acute (Francis & Horn, 2017). College students with early childhood abuse histories were over 50% less likely to complete a 4-year degree than their unharmed counterparts, and 65% experienced PTSD symptoms within the first few weeks of their first year (Duncan,

2000). PTSD symptoms and substance abuse have also been problematic in colleges with the highest dropouts occurring during the 1st year of college as a result of challenges with locating support structures and adjusting to university environments (Borsari et al., 2008).

At the initiation of this study, there were no specific programs available in colleges and universities for students coping with or struggling with symptoms of past and present complex PTSD. Although individual counseling is provided based on student initiative to seek help, it is not enough to address the dynamic symptoms of PTSD.

Purpose of the Study

The purpose of this basic qualitative study was to explore the experiences, beliefs, perceptions, attitudes, and needs of female college students with PTSD and what they identify will guide them towards successful graduation. Many studies have explored the needs of combat veterans returning to college, but few studies exist about civilian women and their various PTSD experiences. In this study, I hoped for emerging themes from interviews that provided a framework for further study and informed college policy and programs for women in this population.

Research Questions

This study was guided by two research questions:

RQ1: How do college females with PTSD describe their academic and social experiences in terms of degree completion?

RQ2: What types of assistance do college female students with PTSD feel is needed to improve their college success?

Conceptual Framework for the Study

I chose feminist trauma theory for this study, which posits that it is necessary to interview women and members of other historically disadvantaged populations about their experiences with trauma in a different way than with the population that various versions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) were created for (Burstow, 2003). Beginning as early as the 1960s and taking shape most notably in the 1990s, changes in the DSM-III-R and DSM-IV were raised by lobbying feminists (Burstow, 2003). This expanded the definitions of trauma to include room for disadvantaged populations to identify and name their experiences and to acquire the tools necessary to treat trauma symptoms, which were redefined as coping skills (Brown, 2006; Burstow, 2003; Pemberton & Loeb, 2020). For example, dominant medical and neoliberal frameworks offer considerable argument about the sociopolitical dimensions of trauma, and trauma definitions such as "outside the range of usual human experience" and "threat to the physical threat of self or other" that describe the criteria for PTSD and have included only dominant ableist culture and excluded the ongoing experiences of oppressed and marginalized populations struggling with trauma caused by racism, transgenerational issues, poverty, classism, genderisms, and context exclusions (Burstow, 2003; Thompson, 2021).

Overall, trauma-informed therapies take into consideration that experience and resiliency are subject to participant perception, interpretation, and expression. In traditional therapy models, the patient is diagnosed using the DSM-5 and treated using the evidence-based interventions commonly taught to therapists in graduate school and

workshops to treat the problems. Embodied in trauma theory is the evidence that contributes knowledge that high adverse childhood experiences (ACEs) scores indicate that trauma affects parts of the brain that regulate physical safety and engage in fight-or-flight, hypervigilant status (Perry, 2001, 2014; Perry & Ludy-Dobson, 2010; Perry & Winfrey, 2021). Some social theorists have posited that pathologizing trauma symptoms leads to further stigmatism and fear of seeking help (Perry, 2001; Perry & Winfrey, 2021).

Feminist trauma theory is an evolving and developing practice that relies heavily on self-determination, self-efficacy, and clear expectations, combined with a focus on trust, transparency, patience with the therapeutic process, safety, and egalitarianism (Pemberton & Loeb, 2020). It cannot be traced back to one individual, as it has been a collective and evolving process since the 1960s, when, despite its best intentions for political and social advancement for women, it excluded women of color and many other populations that were much more marginalized and oppressed than the White women who challenged traditional psychiatric norms designed for middle-class, able White men (Evans et al., 2005). In the 1990s, feminist trauma theory became integral in therapy practices for survivors of interpersonal violence; it has since broadened to include all marginalized and oppressed populations regardless of race or gender (Burstow, 2003; Evans et al., 2005).

This theory challenges assumptions that traumatized people lack appropriate trust and have a less realistic worldview than their untraumatized counterparts do, and that they lack an understanding that the world is an inherently safe place if managed well

(Burstow, 2003). It also attempts to balance the institutionalized psychiatric ruling view of diagnostic, stigmatized mental illness schemas that hold the authority to incarcerate, medicate, and restrict opportunity with the need to accurately help individuals and populations to relieve stressors and achieve success by recognizing that trauma is not a disorder, rather a reaction to a wound (Burstow, 2003; Richmond et al., 2017).

This study explored the experienced relationships between participant PTSD and reported academic norms and expectations. Because institutions of higher education typically resolve student challenges through traditional academic counseling, I wanted to explore the experiences of female students with PTSD and any challenges they may have had in managing their interfering symptoms in higher education using feminist trauma theory to provide conceptual context. A basic qualitative design was appropriate for this study because I explored the academic and social experiences and descriptions pertaining to assistance by female college students with PTSD focused on their degree completion and success (see Bengtsson, 2016; Saldana, 2021; Yin, 2018). Accordingly, the purpose of this study was to explore the experiences, beliefs, perceptions, attitudes, and needs of female college students with PTSD and what they identify will guide them towards successful graduation. I designed the interview protocol using concepts from feminist trauma theory and aligned the research questions to the interview questions. Therefore, I sought to explore the perceptions and experiences, including both challenges and supports, of this population of participants related to PTSD and their experiences in the higher education environment.

The conceptual framework, based on feminist trauma theory, was used in the data analysis process. Specifically, I used the constructs of colonial diagnoses/biological maladaptation, safe environment, self-determination, self-efficacy, trust, transparency, and pathologizing symptoms to conduct a priori coding, a form of deductive coding. I reviewed the transcriptions, searching for language from the participants that was related to the a priori codes. I remained cognizant that there might not be specific evidence of a priori codes identified as well, thus keeping an open mind in the analysis process (see Saldana, 2021; Yin, 2018). The information from the a priori codes and open coding was used to develop categories and resulted in the identification of emerging themes. The identification of the themes directly related to the research questions that guided the study, and the themes were integrated with the literature to describe the findings and to answer the research questions. The results of this study fill a gap in the literature related to academic and social experiences in terms of degree completion, and types of assistance perceived by college female students with PTSD related to their college success.

Nature of the Study

I explored the phenomenon of the experiences, beliefs, perceptions, attitudes, and needs of female university students with PTSD; what they identified would guide them towards successful graduation and influence their success in higher education; and what programs they would like available to promote academic success. This study was a basic qualitative inquiry concerning female college students experiencing symptoms of PTSD. The study design was interpretive and utilized interview questions about participant experiences and perceptions. The approach aimed to define the essence of shared

experience among female college students with PTSD. Varying perspectives about adaptive usefulness exist, which argue both for and against the idea that PTSD is a resilient and adaptive response to trauma (McDonald, 2019). The focus of this study was on what participants experienced and how they experienced it (Creswell, 2013). Based on participant responses, I identified themes and attempted to fill the gap in scholarly literature. As stated in the literature review, I also recognized where participants identified a lack of structured programs to meet the needs of female college students experiencing PTSD.

Participants were drawn from colleges and universities in the United States. After posting invitations on Facebook and in the Walden Participant Pool, I collected 9 semistructured interviews using 10 questions followed by an open-ended question asking for any additional comments or recommendations about how to improve experiences with academic success. Participants were female students who had successfully graduated from a 4-year college or university at some point in their academic journeys and either were enrolled in higher education at the time of the interview or had graduated within the past 5 years. Following the interviews, I hand-coded and analyzed the transcripts, identifying codes, categories, and themes that addressed the study's two research questions. I used content analysis to analyze the transcriptions regarding the experiences of female college students with PTSD in higher education and how their needs were or were not addressed in terms of degree completion. I used both inductive and deductive coding, as Bengtsson (2016) noted that qualitative content analysis is an iterative process of inductive and deductive coding. In the coding process, I decontextualized the data

through the content qualitative analysis process by identifying codes, categories, and emerging themes (Bengtsson, 2016). I then entered raw data highlighted from the interview transcriptions into an Excel spreadsheet. I used the pivot table in the Excel spreadsheet to examine the codes to make deeper meaning of the data in of the coding process. The pivot table allowed me to see the connections in the deductive and inductive coding and supporting the analysis of data by identifying codes, and then collapsing codes to categories and then finally to observe and identify the emerging themes.

Definitions

Academic success: Among other factors, success is defined as graduation from a 4-year college or university (Weatherton & Schussler, 2021).

Anxiety: A condition characterized by symptoms such as difficulty controlling ongoing worry, fatigue, irritability, muscle tension, concentration, mind going blank, restlessness, feeling keyed up, feeling on edge, difficulty falling or staying asleep, and/or has unsatisfying sleep (American Psychiatric Association, 2013).

Bipolar disorder: A complex constellation of symptoms are necessary to meet the DSM-5 diagnosis of bipolar disorder. Symptoms include manic, hypomanic, and/or depressive episodes, and caution should be used to avoid mistaking such symptoms for culture, gender, substance use, anxiety/panic disorders, PTSD, attention deficit disorders, or personality disorders (American Psychiatric Association, 2013).

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5): Used by mental health professionals to classify and organize information to accurately

diagnose individuals for appropriate treatment interventions (American Psychiatric Association, 2013).

Feminist trauma theory: Feminist trauma theory developed to combine trauma theory and feminist psychiatry to account for sociopolitical and economic disparities between male and female trauma experiences, reactions, and presentations (Tseris, 2019).

Posttraumatic stress disorder (PTSD): A complex constellation of symptoms is needed to meet the diagnostic criteria for PTSD in the DSM-5. Symptoms include but are not limited to directly experiencing, learning of, or witnessing a traumatic event in which lives were lost or threatened; experiencing repeated or extreme exposure to deaths or threats; recurrent dreams; intrusive memories; recurrent physical (somatic) or internal memories of events; intense recurring distress to perceived internal or external reminders of events; extreme internal/external reactions to reminders of events; avoidance; inability to remember; negative beliefs about self or others; distorted cognitions; diminished interest or participation in formerly enjoyed activities; feeling detached, unaware of surrounding; inability to experience positive emotions; irritability; always watchful (hypervigilance); reckless or destructive behaviors; problems concentrating; sleep disturbances; exaggerated startle responses; emotions not limited to fear, guilt, shame, sadness; and confusion. Symptoms must be present for at least 1 month (American Psychiatric Association, 2013).

Assumptions

Researchers define assumptions as ideas or constructs thought to be true that are not confirmed by a researcher (Coker, 2022). In qualitative research, it is important to be

transparent in stating assumptions, limitations, and delimitations, and to thoroughly describe the research process to support the quality of the data collection and analysis (see Ravitch & Carl, 2019). I assumed that female students with PTSD would have access to Facebook and LinkedIn, that female students experiencing PTSD would answer questions truthfully and would recall their experiences during interviews, and that the institution of higher education has an obligation to make services available to these students.

With a background in trauma-informed therapy, I made personal assumptions that students coping with PTSD experience negative self-esteem; feelings of low self-worth; avoidance behaviors; substance abuse; isolation; inability to communicate or to make meaning of their experiences; barriers such as family roles, employment, and childcare issues; denial; and identification with the stigmatized population. I also assumed that participants would appreciate college-based programs to meet their trauma needs and that by providing for those needs, it was possible to increase student satisfaction and retention. An assumption based on lack of current literature was that female students who had lived through traumas and who were seeking higher education did not have college-based resources available to them to learn to manage and cope with PTSD symptoms.

This study was prompted due to the few services available for female students with PTSD in higher education and the prevailing gap in academic literature regarding how female college students perceive and experience college success through the lens of PTSD. Examining the perceptions, experiences, and beliefs of female college students with PTSD as they pertained to their university success, I gathered valuable information

on the lived experiences of this population. Consequently, the findings of this study may have implications for ways to strengthen the delivery of services and communication to female students with PTSD enrolled in university degree programs.

Scope and Delimitations

Delimitations are limitations of a study set deliberately by the researcher with the intent of maintaining the boundaries and definitions set for the project (Coker, 2022; Theofanidis & Fountouki, 2018). In this study, only the female population was studied, which limits the study's findings to other populations. However, I wanted to keep the population of my study narrow, considering the lack of published knowledge about the experiences of college student success and PTSD. Another delimitation in this study was that I have PTSD and kept a journal, attended therapy, and conferenced with my committee during to the process to avoid influencing the participant experiences.

I chose a qualitative style for the study with the hope that added information contributed by participants might contribute to literature and to educational policy regarding the successful graduation of female students with PTSD.

Limitations

According to Theofanidis and Fountouki (2018), limitations concern weaknesses in a study that are out of the researcher's control. This study had some limitations. It was limited to female college students found on an online pool, Facebook, and LinkedIn groups, so the study was subject to chance regarding number of respondents. Additionally, the geographical locations of students with PTSD were not taken into account. A limitation included lack of participant full disclosure, meaning that I relied

only on participants' version of the truth and disclosure of PTSD symptoms and experience with PTSD in college, with no supporting documentation. Another limitation of this study was that COVID occurred during the data collection for the study, which could have influenced how participants stated their perceptions, experiences, beliefs, and symptoms. Finally, a limitation may also be that the number and type of participants willing to participate in the study were a subtype cohort (Theofanidis & Fountouki, 2018). Consequently, the findings of this study are limited to the population of participants studied and are not generalizable to other university settings involving female students with PTSD.

I overcame these limitations by using a consistent interview protocol and collection process to maintain the integrity of the data collection and data analysis processes. I ensured trustworthiness by clearly explaining to participants the purpose of the study, addressing the protection of identities, providing documents of confidentiality and privacy, relieving participants of pressure to participate or to maintain at any point during the interview process, and providing interview questions before gaining permission to interview participants. I ensured trustworthiness in gathering and coding data by initially stating that I would transcribe interviews verbatim and analyze data manually.

Additionally, I used a research journal to note thoughts as I interviewed participants and as I coded the interviews. Researchers' journals are used for providing a data set on the act of research in refining the understanding of study participants (see Amin et al., 2020; Janesick, 2011; Laine et al., 2007). I used member-checking to allow

participants to assess accuracy, emailing participants my summary of findings with invitation to check for accuracy regarding the content of their interview data (see Janesick, 2011).

Significance

Through this study, I aimed to fill a gap in literature regarding the understanding of the meaning of complex trauma from female student perspectives, and to make sense of what meaning developed. It is important to provide trauma-informed services in higher education as PTSD traits are prevalent in 56–85% of college students and emotional regulation is dependent on learning healthy skills to manage and cope with underlying reasons and presenting symptoms (Yalch & Levendosky, 2019). Additionally, research indicates that 38.5% of adolescent females who experienced childhood sexual abuse exhibit PTSD symptoms (Chang, et al., 2018). According to the APA, 8% of the 50% of all individuals worldwide who will experience trauma in their lifetimes will develop PTSD (APA, 2023).

Prior to the COVID-19 pandemic, there were already indications of student trauma distress in high schools, colleges, and universities. Since the pandemic, it has become more noticeable that colleges and universities would benefit from adopting trauma-informed policies and practices to encourage the promotion of successful student outcomes and graduation to mitigate the prevalence of shootings, suicides, and other stress-related traumas (see Liang et al., 2020).

Finally, supporting females with PTSD during their 1st year in the college setting is critical to their continued success and retention. Other study findings related to PTSD

symptoms in college students have indicated a need to create trauma-informed wellness resources on campuses during the 1st year and continuing throughout college (Perry & Cuellar, 2022).

I could not locate any college or university programs that had specifically structured support services to address students struggling with PTSD. Family members were not included in the college counseling services, according to a 2018 report from a college counseling administrative department. The overall outcome of the study was to provide information that may help those developing and implementing trauma programs in colleges, to improve capacity building performance, and to improve the academic experiences of female students with PTSD.

Summary

One out of 10 American women will develop PTSD symptoms, compared to one in 20 men (PTSD United, 2022). University-level programs addressing PTSD and providing helpful interventions for women are currently not available, despite studies indicating that women struggle with PTSD at a rate overwhelmingly larger than men, as well as due to uniquely female experiences with misogyny (PTSD United).

Furthermore, women have been known historically as mothers, nurturers, healers, and teachers. While both shame and deficit culture ideologies prevent people from seeking help for PTSD symptoms, women are often underrepresented despite their high percentage of trauma (Brown, 2006). In a global, social, and political system that stigmatizes mental illness and regards adverse reactions to trauma as mental illness, college students attempting to navigate the academic system may be blind to all

symptoms of trauma and may be at risk of failing without programs developed to address their needs (Khanam et al., 2016).

In Chapter 1, I introduced the study, reviewed the background of the problem, and discussed the problem. I provided an overview of the purpose of the study, followed by RQs that I used to investigate the phenomenon of the perceptions, beliefs, and experiences of female students with PTSD in higher education related to their success and academic and support services available to meet their needs as a result of their trauma. In Chapter 1, I also included the conceptual framework and nature of the study; definitions of key terms; and the assumptions, scope and delimitations, limitations, and significance of this basic qualitative study.

In Chapter 2, I include a review of the literature on female students with PTSD in higher education related to their success. I discuss the conceptual framework, feminist trauma theory (Burstow, 2003; Stopforth, 2015). I also provide a critical analysis of current research studies regarding the support of female students with PTSD in higher education and support received by university service providers, and their success in the university setting.

Chapter 2: Literature Review

This chapter is a review of the reasons for college dropout and the prevalence of female PTSD. In addressing these topics, a need for campus-based trauma interventions for women was identified. The lives of female trauma survivors are often multifaceted. Characterized by power differentials, betrayals, self-blame, family conflict, and stigmas both internalized and societal, women struggling to cope with symptoms of PTSD often lead dual realities while trying to fit into male-dominated theories of accepted behaviors. Feminist trauma theorists identify that empowering woman to either claim or reclaim their ability to express their experiences within the context and language in which those events happened and to make meaning of their experiences is more effective in treating traditional diagnoses than cognitive-behavioral psychiatric approaches that focus primarily on biology, neurobiology, and changing thoughts and behaviors to meet societies' criteria for "normalcy" (Tseris, 2019). The literature indicated that straightforward counseling involving standardized treatments including symptom management techniques such as relaxation, mindfulness, and reframing is not enough to cure historical, present, and ongoing abuses specific to women due to a Eurocentric, patriarchal model of social health and justice (Tseris, 2019).

In this chapter, I outline the themes presented in the literature. The gap found was that despite an abundance of information regarding student retention, trauma, neurobiology, social consequences of trauma, and counseling services, I found no literature that focuses on programs intended specifically to address the needs of female college students struggling to cope with symptoms of PTSD.

Literature Search Strategy

Understanding the phenomenon that is the focus of the study is critical to presenting in a thorough and integrated manner. The depth and breadth of the literature review are central to establishing the research that has been completed on the problem being studied and also provide evidence of the gap in the literature. Moreover, exploring researchers' findings related to the phenomenon provides a backdrop pertaining to the problem and helps the researcher describe the integrated research findings related to the focus of the research study. Thus, I used a search strategy concentrating on peer-reviewed literature focused on the following databases and search engines: ProQuest Central, Science Direct, Sage Premier, EBSCO host, SocINDEX with Full Text, ERIC, and Google Scholar. I also compared these sources to outside sources such as books; websites; documentaries about PTSD and women; the nature of PTSD; and how PTSD affects various people. Key search words included *college, trauma, PTSD, student outcomes, women, reasons, dropout, college success, feminist trauma theory, post-traumatic stress disorder, programs, complex trauma, support, mental disorders, student retention, interventions, wellness centers, resiliency,* and *persistenc*e. Most of the peer-reviewed journals were quantitative studies related to populations with PTSD or other traumas.

Conceptual Framework

The primary theory used for this study was feminist trauma theory, derived from socioeconomic, physical, spiritual, and environmental differences between female and male experiences of trauma (Tseris, 2019). It is important to note that what makes

feminist theory stand apart from other theories is that feminist theory applies an underlying set of principles throughout the research (Beckman, 2014). There are eight principles of feminist methodology: (a) explore power imbalances, (b) expand on the research questions, (c) listen to experiences; (d) emphasize diversity and intersectionality; (e) explore social relationships during the process; (f) practice reflexivity; and (g) use the research results as a means to improve principles of equality and egalitarianism (Beckman, 2014).

Feminist trauma theory developed from feminist concepts that explain uniquely female experiences illustrating disruptive, disturbing, and painful socioeconomic and political experiences (Burstow, 2003; Stopforth, 2015). It has evolved as a blending of feminist theory and adapting trauma practice to meet the needs expressed by affected populations (Burstow, 2003; Stopforth, 2015). Recognizing body and space within the female rather than male context is significant in making meaning of trauma, as female physical experience is defined differently among women than it is in the outer, male context (Stopforth, 2015). Feminist trauma theory seeks to develop a connection and empower women to make sense and meaning of their experiences within the context of female experience rather than historically male interpretations, and often encompassing oppressed populations and betrayal trauma (Kline & Palm Reed, 2021; Moore, 2017).

Furthermore, feminist trauma theory differentiates between gendered social, economic, behavioral, and mental health experiences (Tseris, 2019). Shame resilience theory was explored by a modern social worker who authored many books on the topic of female trauma, shame, and resiliency (Brown, 2006). Brown (2006) explored how

recognizing and managing shame responses to adverse experiences create a healthier society of women. Although all genders experience trauma, the female experience is fundamentally different from the male experience due to biological differences, social norms, and expectations (Tseris, 2019).

The methodological basis for this qualitative study was an exploration of the experiences of female college students who had been diagnosed with having PTSD and reports as having received some treatment for PTSD. The conceptual framework was drawn from trauma-informed therapies and advances in educational leadership, as well as neurobiology and social learning theory (Morelli et al., 2021; Perry, 2001, 2014; Perry & Ludy-Dobson, 2010; Perry & Winfrey, 2021). Trauma-informed therapies indicate that experience and resiliency are subject to participant perception, interpretation, expression, and social support. In particular, I chose feminist trauma therapy because since the 1960s, it has been a developing theory that shares a combination of feminist theory and feminist therapy inclusive of all marginalized populations (Burstow, 2003; Evans et al., 2005). Feminist trauma theory has been described as consciousness-raising, inviting new questions about discrimination, bias, social roles, privilege, power, oppression, and different ways of creating equity, inclusion, and positive social change in communities, schools, and therapeutic milieus (Evans, et al., 2005).

Bruce Perry's theory of trauma (Perry, 2001, 2014; Perry & Ludy-Dobson, 2010; Perry & Winfrey, 2021), Brene Brown's shame theory (2006), and other theories including feminist trauma theory suggest that traumas, whether acute or chronic, occurring within the 1st year of childhood development determine unsuccessful lifetime

outcomes, especially about education. The need to understand the neurobiological consequences of poverty, homelessness, and domestic chaos is key in developing programs to meet student needs (Perry & Ludy-Dobson, 2010). Perry's (Perry, 2010; Perry & Ludy-Dobson, 2010; Perry & Winfrey, 2021) neurobiological theory aims to inform policy with the intent of developing educational programs that restore negative repetitive patterns formed in the prefrontal cortex within the 1st year of childhood to positive repetitive patterns later in life when these connections are more difficult.

To date, while combat PTSD explains differentiations in unique experiences involving employments and social conditions leading to PTSD symptoms, PTSD experienced by females is described primarily as involving sexual traumas, which is not entirely accurate. The feminist theory posits that PTSD involving women may not have only to do with sexual trauma, but with experiential circumstances (Harris et al., 2021). Because feminist theory regarding trauma appears to have been abandoned in the late 1900s and early 2000s, I selected this theory as the conceptual framework for this study as it aligns to the phenomenon being studied about how university female students with experiences with PTSD perceive and describe their success in higher education, and what programs they indicate would promote their academic success (see Smith & Freyd, 2014). Moreover, an aim of this study was to add to contemporary knowledge and research on female college students with PTSD.

Literature Review Related to Key Concepts

Power Differentials

In 1993, dropout rates of the Indigenous female population in the U.S. were being studied (Bowker, 1993; Smith & Freyd, 2014). One large study found that the reasons for female college dropout among female Native American populations included personal challenges, family problems, poverty, and poor relationships with teachers, most often due to lack of cultural awareness or sensitivity (Bowker, 1993). Fortunately, since studies about this vulnerable population continued to progress, college graduation rates have increased to around 44% within the Native American population, with approximately 61% being women, a 20% increase since 1980 (National Center for Education Statistics [NCES], 2019). In Bowker's (1993) book, graduation success included having a caring mentor, a keen sense of universal support, and low family stress. For these factors to develop, changes in policy had to be imparted (Bowker, 1993; Dennehy & Dasgupta, 2017). Although this study is not specific to Indigenous populations, factors such as single parenting, poverty, low family support, and lack of institutional cultural awareness about cultures outside the norm are relevant to this study (Bowker, 1993).

Other researchers have asserted that epigenetics contribute to generational differences in education, reasoning that not only is the aging process affected by trauma, but also cognitive functioning, physical health, and mental health are inherited through generations (Boks et al., 2015; Conching & Thayer, 2019). These assertions are not to say that IQ or intellectual abilities are necessarily affected by generational traumas, but that propensities towards certain physical and mental vulnerabilities are. For example, at the

cellular level, Boks et al. (2015) found that although telomere length, which functions in protecting genetic codes, was not affected by traumatic stress, DNA methylation, which directly affects the aging process, was affected, temporarily suspending the aging process.

Disadvantaged and compromised populations such as Holocaust survivors, Native Hawaiians, African Americans, and other populations of historical trauma survivors have been found to relate with generational psychological disturbances not limited to depression, anxiety, PTSD, and physical vulnerabilities towards illness (Conching & Thayer, 2019). Sociopolitical and environmental factors of war, genocide, and terrorism contribute to what is known as biological pathways of trauma, all of which are based on epigenetic theory (Conching & Thayer, 2019). Implications for further research about epigenetics lies in finding helpful interventions for repair and recovery long after the first generation of trauma, as well as studies about hypomethylation, the nervous system, and low socioeconomic status (SES), which have been found as correlating factors (Boyraz et al., 2017; Conching & Thayer, 2019).

Betrayals, Self-Blame, and Family Conflict

The Adverse Childhood Experience (ACE) Project also confirms the relationship between trauma and development later in life (Butler et al., 2018). In this study originating from a 1994 research project conducted by the Kaiser Permanente Medical Care Program, 10 questions addressing adverse childhood experiences profoundly raised risks of adult success from neurological development, socioemotional and cognitive development, at-risk behaviors, the risk for disease, and early death (Centers for Disease

Control and Prevention [CDC], 2021). The ACE model continues to be utilized today by mental health practitioners to assess the degree of trauma impact on daily living. As research about genetics and mental and physical repercussions of trauma continues to develop, the correlations between stress and achievement draw closer to one another (European Society for Traumatic Stress Studies, 2017).

Additionally, because it is not an easy process to drop out of higher education, it is important to acknowledge this process and its implications for early intervention. One study found that female dropout rates occurred at all stages of education, from beginning to towards the end, and for several reasons (Khanam et al., 2016). Because higher education strengthens communities, states, and countries, there is considerable interest in strengthening higher education and graduation across both genders. Khanam et al. (2016) posited that dropout rates reduce economic and environmental advancements as well as global development. Monies spent on education without certificates and diplomas is wasted. Moreover, Khanam et al. found that dropout rates were the result of financial, social, and personal problems.

Mental Health Stigma

Neurobiology and social theorists argue that contemporary research indicates that policies, interventions, and programs designed to address learning difficulties related to childhood traumas are not working and that previous programs are ineffective in addressing student traumas and retention in education, even at the university level (Perry et al., 2018). The need to develop a policy to promote success at all levels of education is paramount to developing a healthy economic, social, and emotional society (Perry, 2001).

College Dropout

Challenges are confronted within the 1st year of college by all students, and dropout rates are highest within the 1st year (Research.com, 2023). This has been explained as a type of culture shock, from family and community values and norms to institutional values and norms. Female students are particularly vulnerable due to sudden lack of immediate family support, male-dominated college culture and social expectations, and perceived support expectations versus real support (Zalazar-Jaime et al., 2017). In short, college culture is based on a historically Eurocentric, White male construct, and females may or may not be prepared for the sudden shift in expectations, depending on their backgrounds. Whereas precollege males are prepared to be externally motivated and females internally motivated, college demands that women adapt quickly to external motivations (Zalazar-Jaime et al., 2017). However, in both male and female dropout rates, perception of goal progress rather than actual progress determines retention rates more than any other factors (Zalazar-Jaime et al., 2017).

Furthermore, social-emotional skills play a large part in college retention (Litoui & Oproui, 2018). The transition from high school to college is difficult for some due to the ambivalence between autonomy and independence versus sudden lack of familiar support. Differences in exams, faculty, social norms, and values in conjunction with transitioning to new and unfamiliar environments contribute to 1st-year dropout rates (Litoui & Oproui, 2018). Feedback from students resulted in promising higher retention rates if the need for managing stress and stressors, time management, task priorities, managing heightened emotions effectively, acquiring help with finances, study

environment, and communication and relationship are met (Litoui & Oproui, 2018). Along with these implications is the suggested responsibility of higher institutions to train faculty and implement progressive policy to meet the growing needs of contemporary students.

Researchers studying the 1st-year student's psychological characteristics on learning performance and retention have suggested that universities engage 1st-year students in situational interests to facilitate greater collaboration between the office of student affairs and the office of academic affairs in the interest of identifying and nurturing academic strengths among diverse groups of incoming students (Cheng et al., 2018). This could be achieved by holding working and focus groups to gather information and gain an understanding of the daily realities of students. In another study, retention rates were found to be higher in colleges and universities in which residential housing programs were strong and inclusive of all students, therefore providing socioemotional, spiritual, financial, and academic support (Kokaua et al., 2018).

Unfortunately, such support is not yet common, and college retention rates continue to be of concern. First-generation college students are often unprepared for the socioeconomic, financial, and academic stresses involved in gaining an education and can lose sight of the end goal without additional supports to turn to. Higher dropout rates have been found in first-generation students due to lower academic self-efficacy (Resko, 2017). Studies about second-generation student college dropout and retention, especially for those raised by single and/or low-income parents, might add to this body of knowledge. Self-efficacy and personality traits combined with resiliency and hardiness

were determined to be predictors of academic success and college retention (Resko, 2017). There is a need for educators to be trained to recognize and address the needs of students deficient in these attributes (e.g., resiliency and hardiness), and for the creation of policies to address student requirements for financial, social, and faculty relationships (Resko, 2017).

Both college enrollments and dropout rates are on the rise, dropouts being approximately 24% of the rising enrollment numbers (Gray & Swinton, 2017). In one study, two primary factors determine college retention. Academic and social integration are key motivators to remain in higher education and to complete degrees (Gray & Swinton, 2017). Given the isolating nature of PTSD symptoms, socialization was explored in this study.

Researchers have examined the relationship between traditional models of higher education and unique challenges that Millennials and Generation Z students present with their advanced and global understandings due to technological advances (Romsa et al., 2017). Millennials--born 1980-1994--are less likely to drop out of college than Generation Z--born 1995-2012--because the Baby Boomers--born 1946-194-- and overlapping Generation X--1965-1979--worked with societal beliefs at the time to instill pressures for Millennials to achieve in college, whereas Gen Z students rely primarily on technology to communicate and to do their work (Romsa et al., 2017). However, there is speculation that the GenZ population will remain in higher education longer than previous generations.

In 2003 the National Center for Education Statistics (NCES) reported that two-thirds of students enrolling in college were non-traditional, indicating that the late Baby Boomers and early GenX were working to catch up to educational standards and workforce requirements (NCES, 2019). This information may be particularly relevant to this study, as patterns indicate a disruption in attendance during the 1990s, meaning that more non-traditional students are returning to the educational arena after years of life experience. In current times, generations are clashing with political conversations and educational norms as technological influences add to the complexity of relationships. According to research regarding dropout reasons and rates the need for mentorship, parental stimulation, mature guidance, and relationship is stronger than ever before (Romsa et al., 2017). The GenZ population is especially responsive to mentorship and positive guidance by older adults. Furthermore, current studies found that college satisfaction fails current generations by not keeping up with the emotional needs of the new generations (Toppo, 2017). Millennials, once optimistic about finishing college and acquiring profitable positions in society, have become disillusioned and pessimistic as educational debts and poor job markets have failed their expectations (Toppo, 2017). Diversely, GenZ students are learning from Millennials and are pushing back to some degree to demand that the educational system cooperates with them, using technology and strong peer relationships as leverage while vocalizing that the archaic demands of traditional education no longer make sense with the challenges of today (Toppo, 2017).

Although the distance between individuals has been touted as irrelevant due to technological advances, eye-to-eye contact, direct experiences, and one-on-one

relationships continue to be important to all generations. Despite the advantages of technology, the importance of relationships continues to be a priority in the human experience. By 2020 military models asserted that educational institutions must be ready to meet the Gen Z group where they are in their completely internet literate capacity, yet also be available to meet inherent basic human needs (Bodescu, 2017). Adapting teaching models to accommodate new students involves developing peer-to-peer interactions between older faculty and younger students (Chicioreanu & Amza, 2018). Concerning women, one landmark study found that female to female peer support provided positive intervention and increased academic development tremendously (APA, 2023; Monk et al., 2017).

Trauma-Related Disorders

Trauma interfering with the daily activities of living is most commonly referred to as posttraumatic stress disorder due to complex trauma symptoms typically meeting the DSM-5 (APA, 2020) criteria for PTSD. Other more specific types of traumas such as acute trauma disorder, depression, anxiety, traumatic brain injury, reactive attachment disorder, etc. are specifically treated for targeted symptoms which present as less complex during daily the daily process of conducting one's day. Borderline personality disorder and bipolar disorders are often misdiagnosed before resorting to PTSD due to stigmas surrounding female trauma experiences and the typically male combat veteran association with PTSD. Additionally, aside from bipolar and borderline personality disorders, the other less stigmatized disorders are often diagnosed as "rule outs" by mental health professionals, meaning that treatments and interventions will target

depression, adjustment disorder, anxieties, etc. before diagnosing with the more stigmatized diagnosis of PTSD.

Anxiety disorder is the most prevalent of all disorders in the U.S. today, and especially among college students, adversely affecting cortisol reactivity (Bruijnen et al., 2019). Reasons for this include childhood trauma; quickly changing social norms spanning schools; technology; and economy; all which have shaped a changing sociopolitical climate. Factors such as climate change, immigration policies, wars since 9/11, and various forms of discrimination have contributed to the anxieties that drive our youth's decisions (McMahon & Bernard, 2019). Another factor contributing to youth and anxiety is the distance between moral standards of previous, traditional, and Westernized generations compared to the moral realities of Generation Y and Z students who capitulated into a form of posttraumatic stress as they came to understand that their sense of safety relied on rote conditioning versus "woke" comprehension of the environment in danger in which they have found themselves "shook." For example, scholars have found and continue to find that assumptions based on empirical evidence are not immune to further scrutiny (Iannone, 2017). As national and global policies shift and change, young people's observations, perceptions, and reactions or behaviors change as well.

Furthermore, global, and local catastrophic tragedies have shaped perceptions and contributed to anxious behaviors. Traumatic childhood experiences are the most important risk factors for PTSD (Aslaner et al., 2019). Numerous interviews and studies exploring the experiences and thinking processes of young people dealing with crises including economic hardships, national disasters, and family situations illustrate the

severity and complexity of mental and emotional needs in our country (Symptom Media (Producer), 2018).

Eating disorders are another outcome of trauma and are historically more complex if not more difficult to treat than substance abuse. Currently, 17-90% of the female college population are developing or are struggling with an eating disorder (Harrer et al., 2020). Given that eating disorders have up to a 97% comorbidity rate with trauma-related diagnoses and are misunderstood in terms of mental illness, increased funding and resources have been recommended to address the problem in colleges (NEDA, 2022). In one study, the lack of trust, lack of sense of autonomy and security, anxiety associated with feelings of abandonment and detachment were found to contribute to the presence of eating disorders (Olofsson et al., 2019). Additionally, the researchers found that therapeutic interventions promoting assertiveness and boundary-setting, staff support, allowing vulnerability and others to care for them, positive relationships with a therapist, exploration of traumatic experiences, learning safe contact with bodily experiences, mirroring with other patients, and psychoeducation helped maintain health (Olofsson et al., 2019). Factors that were not helpful and resulted in relapses were feelings that treatment was for the benefit of others, losing the feeling of security once the program ended and patients no longer had the level of support maintained, feeling threatened being cared for by others, poor relationships with therapists, not working through past traumas, and adverse feelings about coming in contact with the body (Olofsson et al., 2019).

Borderline personality (BPD) traits have come under scrutiny in recent years, with untreated trauma being the single cause of developing maladaptive coping skills, thinking issues, and disordered personality traits (Parent & Ferriter, 2018). While not every person exhibiting borderline personality traits warrants a diagnosis of BPD, the traits are maladaptive and inconducive to healthy lifestyle habits and learning if not addressed. These traits are described by the DSM 5 as having a pattern of poor self-image, impulsivity, unstable effects, and relationship problems. The primary type of trauma associated with BPD is betrayal trauma, with symptoms in order of severity being anxiety, depression, difficult or no control over emotions, hostility, impulsivity, risk-taking, and separation insecurity (Parent & Ferriter, 2018). Interestingly, these traits are also present in those experiencing PTSD which is also caused by trauma and is prevalent in college students.

PTSD traits are prevalent in 56-85% of college students (Yalch & Levendosky, 2019). In one study the relationship of PTSD to smoking was studied and nicotine use was linked to PTSD, because smoking temporarily decreased feelings of irritability, hypervigilance, and difficulty concentrating (Yalch & Levendosky, 2019). Emotional dysregulation is also common in students with PTSD, with child maltreatment in women being the largest common factor (Gabert-Quillen et al., 2015). Emotional regulation is dependent on psychoeducation to learn acceptance, evidence-based coping skills, and self-awareness (O'Bryan et al., 2015). Researchers found that the rate of PTSD in adolescent females who had experienced childhood sexual abuse was 38.5%, with emotional regulation challenges being linked to PTSD symptoms (Chang et al., 2018).

Furthermore, the American Psychological Association (APA) reports that of the 50% of all individuals worldwide who will experience trauma in their lifetimes, 8% of them will develop PTSD (APA, 2023).

Finally, supporting females with PTSD in college during their first year in the college setting is critical to their continued success and retention. Other study findings related to PTSD symptoms in college students indicated the need to develop trauma-informed wellness resources on campuses was recommended, especially during the first year of college and continuing throughout (Perry & Cuellar, 2022). The reason for this is the high percentage of students with trauma symptoms found to interfere with academic performance and retention.

Diagnostic and Statistical Manual of Mental Disorders (5th ed.) Criteria for Posttraumatic Stress Disorder

It is helpful to understand how the Diagnostic and Statistical Manual of Mental Disorders defines the conditions and standards necessary to meet the diagnosis of PTSD, keeping in mind that there are scholars who argue that the DSM is a working political document, which uses the term “disorder” subjectively, as it once included hysteria, homosexuality, and a runaway slave as mental health disorder (APA, 2023). The manual is the document necessary to diagnose patients with a medical mental health disorder for which to bill insurance and receive treatment from licensed health professionals.

It is possible that dropout rates and students struggling with symptoms of trauma also struggle academically. Counseling centers are modeled to effectively address these needs of students yet fall short by focusing on suicide prevention and other high-risk

behaviors without filling the need for more moderate, preventative services that reduce mental health stigmas and encourage help-seeking behaviors before they become acute (Francis & Horn, 2017).

Female PTSD

Although PTSD is becoming a topic of interest due to present national and global events including war and terrorism, PTSD in women continues to rise at about twice the rate as that of men (American Psychiatric Nurses Association [APNA], 2018). The American Psychological Association (APA) recommends increased funding for research, increased training regarding women and trauma, and increased services for female survivors and their families (APNA, 2018). This is because despite modern advances women continue to be subjects of domestic and sexual violence at all ages and cultures.

Furthermore, increased PTSD rates in women contribute to comorbid mental health diagnoses, substance use disorders, and physical problems (APNA, 2018). Gastro-intestinal problems, sexual dysfunctions, depression, anxiety, insomnia, and self-medication are some disruptions that women with PTSD experience (APNA, 2018). Women with PTSD are less likely to seek professional help due to feelings of shame and stigmas about the trauma events leading to the development of PTSD, and their symptoms are less likely to be recognized as unusual due to gender stereotypes (American Psychiatric Association, 2013; National Institute of Mental Health, 2019). Consequently, eating and substance use disorders are common. However, women were found to have a significantly lower dropout rate than men were in recent studies, largely

because of their conditioned need for positive social support which narrative, cognitive behavioral therapy, and other common therapies provide (Bisson Desrochers et al., 2016).

Some researchers acknowledge the need for additional research and information on supporting female university students with PTSD. In one qualitative study, researchers focused on the sexual trauma of female students in the college environment by administering a school climate survey was administered to all faculty and staff at on university site. The findings established the need for college-wide trauma-informed programs directed towards the education and training of faculty and staff (Sales & Krause, 2017.) Boyraz and Granda (2019) maintained the need for additional research pertaining to women, early childhood trauma, and recommendations for programs related to the general idea of women and trauma. Other researchers have found that women diagnosed with a borderline personality disorder, which carries more stigma and disabilities that PTSD, have benefitted from a feminist trauma theory approach (Harned et al., 2018). Harned, et al. (2018) found that when women who were diagnosed with borderline personality disorder were treated for PTSD their symptoms decreased significantly.

Although female PTSD is more prevalent than male PTSD, women experiencing symptoms are more likely to be referred to as depressed, anxious, neurotic, emotional, etc. Additionally, women are less likely to benefit from psychotherapy and medication yet are more likely to benefit from validating interventions that improve social health (Duberstein, et al., 2018). Social inclusion, relationship-building, and personal empowerment are key to effective interventions.

Symptom Presentation

The stereotypical image of a person with PTSD is a controlled male combat veteran who self-medicates with alcohol after work and has frequent violent outbursts towards his family. However, this stereotype is not accurate. PTSD symptoms are most often managed by the sufferer and are rarely made public or are characterized by having displays of violence. PTSD symptoms include chronic fatigue, irritability, and hypervigilance. As previously noted, although combat PTSD is highest in men, females are much more likely to suffer from PTSD symptoms in the general population due to chronic stress and complex trauma experiences (Mendoza et al., 2016). The outward expression of symptoms in both men and women include irritability, minor verbal outbursts, avoidance behaviors, social withdrawal, controlling behaviors, eating and/or substance use disorders, as well as a wide range of emotions (APA, 2013). Individuals with PTSD may abuse food and other substances to avoid reliving experiences, feelings, shame, insomnia and/or nightmares, or limiting factors, or out of fear of hurting others with their sense of having powerful emotions (Trottier et al., 2017).

Women are misdiagnosed with comorbid disorders more frequently than men are. Symptoms in women are similar to depression, anxiety, borderline personality disorder, general anxiety disorder, bipolar disorder, and other disorders commonly attributed to the female population. Attention-deficit hyperactive disorder (ADHD) is most commonly misattributed to the male population with PTSD (Bangasser et al., 2019). While substance abuse is often a factor in symptom self-management, females seek help for substance use disorders at a lesser frequency than males. Moreover, females report

feeling outnumbered by males in programs intended for help with substance use disorders (Mundon et al., 2015). Rather than feel outnumbered and ridiculed women tend to avoid self-help groups in favor of groups without a particular mental health agenda. Symptomology in college students may be difficult to recognize as this age group is behaviorally and emotionally experimental by stages of development. However, it is possible that if studied this population would be forthcoming about symptoms and history of traumas. Finally, despite age or gender groups, symptoms of PTSD present with similarity and congruency with the DSM-V (APA, 2013).

Posttraumatic Stress Disorder Resulting in College Dropout

There is little known about college dropout rates resulting from PTSD. Until the past twenty years, PTSD was explored within the context of war and combat veterans, while trauma symptoms outside of these parameters were treated as other diagnoses or not at all (Bisson Desrocher et al., 2016). Women in history have been researched in the context of college retention and dropout in terms of ethnic or racial minority status, depression, family, and social barriers which have been contributors to dropout (Arbona et al., 2018). I was not able to find research to substantiate PTSD as a reason for female college dropout, thus identifying a gap in research.

One longitudinal study found that college students with early childhood abuse histories were over 50% less likely to complete a 4-year degree than their unharmed counterparts, and 65% experienced PTSD symptoms within the first few weeks of their first year (Duncan, 2000). PTSD symptoms and substance abuse have also been problematic in college, the first year being the most indicative of dropout due to poor

adaptation to college life (Borsari et al., 2008). Researchers indicated that there were no significant correlations between PTSD and college graduations or dropouts. However, the authors posited that trauma symptoms combined with other risk factors not taken into consideration like poverty, lack of social support, and emphasized a need for further research about PTSD and college dropout (Boyraz & Granda, 2019). Studies indicated that regardless of past traumas students with higher high school grade point averages graduated more frequently than those without.

Neurobiology and Posttraumatic Stress Disorder

Much has been written about how trauma affects the brain. PTSD affects the young male brain in markedly more diverse ways that it affects the young female brain, thus indicating gender-specific therapeutic interventions may be warranted (Klabunde et al., 2017). Male and female brains show little if any differences in control groups, yet traumatized group brain structures vary about the insula's anterior circular sulcus, an area that processes empathy and other emotions (Klabunde et al., 2017). Reliving events or "flashbacks" caused by triggers also called "symptom provocation" originate as a result of cerebral blood flow to the amygdala and other areas of the brain that regulate emotion, fight, or flight responses, and other signals of primal survival (Floriou-Servou et al., 2021). Areas of the brain that are most affected by trauma control emotional regulation, cognitive processing, communication, and the parasympathetic nervous system which has a symbiotic relationship with the autonomic nervous system (Klabunde et al., 2017). Both of these systems regulate voluntary and involuntary interactions about overall coronary digestive health, the nervous system, and outward expressions of stress.

Further research has found decreased cortisol levels, neuroendocrine challenges, norepinephrine, and irregular serotonin and dopamine levels in people with PTSD Floriou-Servou et al., 2021). The body's inflammatory response becomes overactive, sex hormones are disrupted or dysregulated, depression, migraines, insomnia, irritable bowel syndrome, and significant hormonal changes occur in both males and females, with females being most remarkably affected (Mendoza et al., 2016). Furthermore, the most significant system affected in both males and females is the immune system due to neuroinflammation which affects parts of the brain, organs, autonomic, and parasympathetic nervous systems (Mendoza et al., 2016).

As previously mentioned, recent studies about epigenetics indicate a correlation between DNA determinants and generational trauma, thus providing a reason to explore ways to provide adequate psychological care to students. For the purpose of this study female students were of interest as a means to provide succinct direction and purpose in findings. Recent studies suggest that sleep plays a significant role in treating trauma and that PTSD sufferers may benefit from REM focused sleep treatments and other interventions aimed at consolidating emotional reactions to the trauma associated with the amygdala (Murkar & De Koninck, 2018).

Developments in Posttraumatic Stress Disorder Research

Research about PTSD continues to develop as human traumas progress worldwide. The last three generations have experienced a surge in trauma with access to information, current events such as wars, school shootings, record shootings and bombings in places of worship, as well as the more usual forms of trauma such as

complex childhood and sexual traumas. In the past 20 years or more, trauma research has attempted to understand everything from 9-11 events to any tragic event presenting on the news or handheld device at any given time.

The #MeToo movement opened an abundance of questions inviting trauma research. Social scientists like Brene Brown are rapidly becoming popular as inquiry explores all facets of trauma including vulnerability, courage, shame, resiliency, thus changing the culture of the workforce, opening doors, and ending the silence of generations of traumatized young people, men, and women (Brown, 2006; Traub & Van Hoose Garofalo, 2019). Trauma-information, self-help, resources, direction, awareness, and support can be located anywhere from Amazon Prime, TedTalks, Netflix, and beyond.

Trauma research increasingly emerges with everything from emotional, physical, sexual, environmental, workplace, spiritual, financial, domestic, and international traumas. The U.S. military has increased support for members enlisted at home and abroad with policy and program incentives to treat members for symptoms and behaviors associated with trauma as preventative and curative measures (USVA, 2019). Schools, colleges, and universities are having to address trauma prevention and treatment as increased gun violence raises concerns about mental health in communities.

According to Tiwari and Gonzalez (2018), females develop significantly higher rates of depression, anxiety, panic disorder, and PTSD than males do, and at a rate of over twice as much. This information is consistent with all findings from researchers

including many conclusions involving epigenetics, neurobiology, social, and gender-specific factors (see Ponomareva & Ressler, 2021; Veldhuis et al., 2023).

The Center for Collegiate Mental Health (2017, January) revealed that more women than men were first-generation college students; identified finances as stressful during and before college; identified families as a source of support; sought mental health services; were hospitalized for mental health concerns; were confronted about substance use/misuse; purposely injured themselves; attempted suicide; had sexual contact without giving consent; experienced harassment and abuse; and experienced a traumatic event. Of the traumatic events, more women than men identified childhood physical abuse, childhood sexual abuse, sexual violence, kidnapping/hostage instances, and "other" (Center for Collegiate Mental Health, 2017). In 2016, the same center found that alcohol use was down, marijuana use increased, yet other evidenced percentages remained the same (Center for Collegiate Mental Health, 2017).

Consequences of Unattended Trauma

Those who struggle to cope with traumatic experiences or who are overlooked often struggle with comorbid mental and physical health diagnoses. Phobias, repetitive behaviors, and maladaptive patterns, suicidality, self-harm, substance misuse are common symptoms (see Valentine et al., 2023). Fight, flight, or freeze are common reactions to daily stressors despite the lack of actual threat (Van der Kolk, 2022). In exploring the stress-disease connection, multiple studies correlated respiratory, adrenal, tumor, coronary, and digestive disorders to those suffering from untreated traumas (Mate, 2022). Eating disorders are common in females with PTSD, as both avoidance and

controlling mechanisms contribute to manage physical and sexual abuse (Trottier et al., 2017).

Socioenvironmental and sociocultural consequences of unattended trauma include random acts of violence in schools and communities which most notably started with the Columbine High School shooting of 1999 and began a pattern of violently expressive school shootings (Muschert, 2019). As shootings continued, school bullying and adolescent suicides also became a matter of growing concern as parents, families, educators, and policymakers struggled to understand mental health concerns and ways to help (DeMatthews & Brown, 2019). In summary, the consequences of unattended trauma and the resulting symptoms are continuing to affect the lives of individuals who have experienced trauma until trauma-informed interventions are implemented.

While PTSD symptoms encompass much more than depressive symptoms, studies indicate that students experiencing symptoms of depression also experience depleted effort regulations (Boyraz & Granda, 2019). Additionally, as the relationship between depression and self-regulation goes unattended, academic performance can struggle when emotions become more intense, and motivation to tackle difficult tasks decreases.

Trauma and Humor

Emotional pain, struggle, fragility, and vulnerability remain taboo in mainstream Western society, despite large advances with the emergence of the young GenZ culture. Through the use of humor, however, we can provide a sense of detachment from traumas and provide a framework for which to discuss sensitive and painful topics with a sense of familiarity and vicarious empathy (Thomas et al., 2022). In this way, we don’t have to

"own" the shameful trauma yet can address it as humor offers a therapeutic outlet. Humor is a complex coping behavior that is instrumental in resiliency and recovery (Cherry et al., 2018). One study found that populations struggling with grave natural disasters fared well over time as they were able to cope with their tragedies by using humor, and sometimes dark humor (Cherry et al., 2018). This is often common in the helping professions, as it can be a useful way to alleviate pain through humorous sharing which also recognizes the depth of feeling and experience without wallowing in despair. It is also notable that resiliency was stronger when humor was combined with charitable acts, thus building a lasting sense of spiritual resiliency as well (Cherry et al., 2018).

Finally, of the various uses of humor related to trauma-processing affiliative humor, self-enhancing humor, benign humor, self-defeating humor, and aggressive humor only benign humor was found to be a crucial factor in resiliency and coping with trauma (Boerner et al., 2017). All of the other uses of humor contributed to reinforced trauma, avoidant behaviors, improper balances of power, depressive symptoms, and other maladaptive outcomes (Boerner et al., 2017). Understanding how humor applied to trauma can either enhance or reduce positive outcomes lends implications for future research and helpful interventions.

Mental Health Stigma

In an article that addressed political correctness on college campuses, general opinions and norms were in contrast with scientific evidence, finding that the social argument for political correctness often overrides science (Iannone, 2017). Mental health stigma is one of these social norms and is deeply rooted in opinion rather than fact. With

One of four people struggling with mental health issues on any given day in the U.S., few will seek help and 35-50% will not receive help at all (Goldman, 2018). Factors like social and personal discrimination, fear of reprisal, job discrimination, and public stigma prevent people from seeking help. Some educators place help-seeking and ending mental health stigma at the top of their priorities to promote overall well-being in classrooms yet counseling and wellness services campus-wide are undernourished and underfunded (Goldman, 2018). Because of this, Goldman (2018) stresses the importance of systemic and institutionalized, evidence-based mental health and wellness practices to de-stigmatize emotional and mental ailments and provide the healthiest environment possible to meet the growing needs of both students and faculty.

Scholars agree that innovative policies would de-stigmatize mental health help-seeking behaviors and provide options for necessary services in colleges and universities (Gaddis et al., 2018). Gaddis et al discuss the questions from all levels of social responsibility including the micro, mezzo, and macro levels. For example, it is helpful if students and faculty can safely discuss feeling vulnerable at an individual level. It then is helpful to be able take conversations to the public arena (e.g., including wellness and counseling centers). This helps to improve the likelihood of overall community health. For this to happen consistently across the U.S., policy must be developed and implemented. Additionally, recognizing that biological factors inherent in trauma experience inhibit and prevent optimal learning capacity is key to understanding the need for college-level counseling models.

Interestingly, there have been studies based on the effects of mental health and help-seeking stigmas in males (DeBate et al., 2018). In one study, negative attitudes were associated with mental health help-seeking due to deeply ingrained and long-held social beliefs and norms about gender (DeBate et al., 2018). Suggestions for intervening with preventative measures included increasing mental health literacy, increasing education through social marketing interventions directed towards the male population, implementing certified mental health coaches near areas where the needs have proven highest, increasing male-specific coaching in academic coaches and mentors, and implementing comprehensive and easily accessible satellite or distance-learning approaches to mental health (DeBate et al., 2018).

In recent years, mental health solidarity campaigns designed to end mental health stigma in colleges are pondered, with findings implying unity, advocacy, and overall success in bringing students, staff, and instructors together to end the stigmas (Kosyluk et al., 2015). Additionally, students are more likely to seek help for mental issues when objectively provided with information about interventions or programs that will be useful to them personally and professionally (Holttum, 2015). This blend of compassionate caring towards those seeking help provides a stronger sense of inclusion which is helpful in success and retention (Holttum, 2015).

Generational Developments

The newest generation of college students have graduated from college recently, and research suggests that they are the most racially and ethnically different than any other generation before them, many born of refugees and immigrants (Fry & Parker,

2019). Combined, the GenZ generation is more diverse, more educated, less emotionally prepared for college, highly empathetic and worldly due not only to backgrounds but also due to technological advances they were born into, unlike their predecessors (Bosscher, 2019). The reasons for emotional preparedness vary according to the author, but an overall theme seems to suggest that the traditional American collegiate standard does not suit the needs of contemporary students.

Researchers found that students today prefer active, interactive, and dynamic classroom models over professor-lead lectures and top-down teaching styles (Çetin & Halisdemir, 2019). Although inaccurate, the generation born from 1995 until the present is known by perplexed previous generations as being disinterested, entitled, disconnected, unmotivated, and lacking in basic life skills (Çetin & Halisdemir, 2019). Rather, they are highly adept at multi-tasking, socializing in complex ways, creativity, valuing feedback, and vulnerability from others, are goal-focused, and kinder towards all ages, races, ethnicities, and genders than were previous generations (Çetin & Halisdemir, 2019). Unfortunately, the educational process has been unable to keep up with the challenges faced as this new generation floods the system with their superior technological and social acumen. Summarily, previous generations who are in the positions of administrators and educators are finding it necessary to understand this new appearance of fearlessness, disdain for power and classism, and rejection of inherent authority. The new generation prefers peer teaching over lectures, with an understanding that the term peer does not refer to age, but experience and relationship. Authority, punishment, rules, and a one-size-fits-all policy paradigm are not accepted by the GenZ population, as they

value individual uniqueness and relationship more than institutionalization (Çetin & Halisdemir, 2019).

Social media and how it is used has also changed within this generation. In previous generations, MySpace, Facebook, and other types of media were introduced as ways to get to know others and to build online communities. However, as the generation born into technology observed and were victims of online bullying and confidential information used for political and other unsavory interactions, they came to understand the implications for privacy violations and have become private with their interactions (Rospigliosi & Asher, 2019). While this generation continues to enjoy social media, they are less likely to reveal personal information on these platforms.

Interestingly, the educational system is not the only system perplexed by this new and large generation of young learners. The United States military system is also struggling to recruit and retain members (McMahon & Bernard, 2019). A recent study found that of 34 million 17-24-year-olds, 71% do not qualify for the U.S. military due to a lack of education, poor health, or criminal records and the remainder of qualified candidates, less than 1% of those are both qualified and willing to explore opportunities in the military (McMahon & Bernard, 2019). Much of this has to do with national education, health, and criminal justice policy which has shaped the priorities of Gen Z to shift from traditional national policy to national justice and progressive social justice (McMahon & Bernard, 2019).

Contrary to civilian research, the military has put a great deal of time and effort into trying to understand mental health stigma challenges and how to mitigate them. In

accelerated attempts to use evidence-based policy to reverse the notion that mental health issues amount to weakness, the DoD has invested considerable effort to identify personal, practical, and social barriers to help-seeking strategies (Gibbons et al., 2014). By launching an anti-stigmatization movement around 2010, the military has been working to increase mental health services and decrease stigma to reduce spiking self-harming behaviors and suicides in both active duty and veterans (Gibbons et al., 2014). With barriers to mental health considered a global health problem, the military model is attempting to shift the stigma from mental health to a more normative physical health model.

Reasons for military research on mental health, stigmas, and help-seeking behaviors are that since the deployments to Iraq and Afghanistan. Since 2001 trauma and alcohol use disorders have risen to 43% of the military population, and 60% of this population does not seek help (Sharp et al., 2015). Because the military identity and culture value and emphasizes strength, loyalty, pride, and warrior ethos, help-seeking is perceived as repugnant and weak, and as the first step towards disloyalty to the mission (Gibbons et al., 2014). However, the military has worked hard to implement policy to reflect help-seeking behaviors as improving strength and resiliency towards a stronger commitment to the mission, thus decreasing adverse behaviors and most importantly, suicides (Sharp, et al., 2015).

Therapeutic Interventions Targeted for Posttraumatic Stress Disorder

Meditation, mindfulness, yoga, eye movement desensitization and reprocessing (EMDR), re-scripting, neurofeedback, exposure, narrative, art, music, and theater are

among forms of interventions found to be helpful to reduce and eliminate symptoms of PTSD because these forms of therapy help to make sense of fragmenting, invasive, and explosive experiences (Mate, 2022). Cognitive-behavioral therapy (CBT) has also been useful in terms of treating co-occurring symptoms such as depression, anxiety, social withdrawal, and eating disorders by making sense of meaning in terms of understanding how thought patterns, emotions, and behaviors are related (Trottier et al., 2017).

Recent trauma resiliency research has found that chronic distress interferes with the ability to apply resiliency skills, provoking a need for body awareness and mindfulness interventions rooted in neuroscience concepts (Grabbe & Miller-Karas, 2018). In using these methods developed by Trauma Resource Institute and partners, resilient neural pathways are formed enabling trauma survivors to apply resiliency coping skills with success (Grabbe & Miller-Karas, 2018). Early successful treatment for PTSD was EMDR. Coupled with hypnotherapy, a combination of neurobiological and resiliency guardianship is applied to once again, Masson form new and positive neurobiological pathways to replace trauma memories rooted in the biology of the brain and reinforced by consequent hormones (Masson et al., 2016).

While adults benefit from more intricate or multi-involved interventions, youth and adolescents respond well to Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and when used in conjunction with Narrative Exposure Therapy (NET) has shown promise especially in peer-group settings (Peltonen & Kangaslampi, 2019). To summarize, there are many ways to approach trauma and resiliency interventions. As professionals learn more about the nature, biology, and forms of simple and complex

traumas they are better prepared to know how to go about building relationships that are conducive to effective patient communication and patient-directed interventions rather than imposed and ineffective treatments. Researchers have emphasized that trauma-focused treatments such as exposure-based treatments, brief eclectic psychotherapy, cognitive-behavioral and cognitive processing, stress inoculation training, and eye movement desensitization and reprocessing (EMDR) are the most effective interventions for those experiencing trauma symptoms (Gentry et al., 2017). Additionally, perceived social support, stress, and mental health are linked to student achievement and success, regardless of the severity of abuse (Karatekin & Ahluwalia, 2020).

Emerging Topics in Literature

Women and Trauma

While there are similarities between how genders process trauma, particularly about neurobiological findings, fundamental differences in the way women experience and manage their roles regarding stress are different than those of their male counterparts. Traumatic experiences are widely prevalent in our country and of the 45% of our population in the United States who will develop symptoms of posttraumatic stress disorder, most will be women (Perry & Cueller, 2022; PTSD United, 2022). The reasons for this are that the basic tenets of PTSD are experiencing and/or witnessing violence and destruction in such a way as to feel one's basic worldview assumptions are shattered, scattered, and experiencing an overwhelming perception of helplessness to do anything about it (APA, 2013). Women are over twice as likely to develop PTSD due to gendered

conditioning and prevalence of caregiver childhood abuses, sexual assaults, interpersonal betrayal, domestic and social violence (Perry, 2021).

Researchers have indicated that non-White female military veterans report more PTSD symptoms and more sexual traumas than their white counterparts, indicating a need to explore culturally informed interventions (Castillo et al., 2016). Researchers have demonstrated that females exhibit more symptoms of PTSD than males, and that female emotional response to trauma is more prevalent than in males (Hu et al., 2017). Pebole and Hall (2019) found that females with PTSD who suffer from physiological illnesses like fibromyalgia, impaired physical function, anxiety and are less involved in physical activity than males with PTSD are less likely to be chosen for exercise studies.

Symptoms. Symptoms of PTSD include but are not limited to nightmares, insomnia, flashbacks, dissociation, difficulties communicating, resistance to change, tearfulness, anxiety, rages, feeling out of control, feeling an overwhelming need to control, "freezing," memory problems, social withdrawal, shaking, shame, guilt, avoidance behaviors, feelings of detachment and estrangement from others, hypervigilance, difficulty concentrating, reckless and destructive behavior, persistent unhappiness, etc. (APA, 2013).

Symptoms often present with comorbidities such as substance abuse, depression, and anxiety. However, differentiate from other diagnostic clusters due to meeting the criteria of PTSD as experiencing or witnessing actual or threatened death, injury, or sexual violence and experiencing distressing and intrusive symptoms related to that or those experiences (APA, 2013). Women feeling these symptoms often do not recognize

them as PTSD, but as pathologies related to their inability to adapt to a patriarchal construct. Higher education is traditionally an environment in which competitiveness, financial stability, socioeconomic status, white male privilege, emotional control, and even-tempered behaviors are valued (Tseris, 2019). Unfortunately, lack of professional knowledge about PTSD has caused historical misdiagnosis of borderline personality disorder, histrionic personality disorder, and bipolar personality disorder which have symptoms like PTSD, but in their diagnosis re-traumatize people with PTSD by blaming pathological symptoms of environmental abuses on the victims (Tseris, 2019).

Processing the Meaning of Trauma. Making meaning of their experiences and learning to build a range and depth of positive relationships and experiences is key for women managing and recovering from traumas (Champine et al., 2022; Luzzatto et al., 2022). Shame, self-blame, moral injury, and survivor's guilt can undermine authentic self-expression and help-seeking behaviors. More women than men experience interpersonal trauma. The severity and chronicity of trauma determined the development of symptoms and lack of clinical knowledge contributes to ineffective diagnosis and treatment of symptoms. Additionally, women are more likely than men to internalize their experiences as negative self-constructs in which their self-worth is subject to societal feedback (Champine et al., 2022).

Neurobiology. Advances in the biology of the brain and how it reacts to trauma have contributed to implications for treatment programs (Perry et al., 2018). We now know that during the first year of development after birth, the prefrontal cortex is especially sensitive to stimuli and that the greater the stressors are during that first year,

the more difficult learning is in subsequent years (Perry et al., 2018). Other literature informs about specific parts of the brain that are affected by trauma. The hippocampus which manages memory loses volume during chronic stress, the amygdala which manages the “fight or flight” responses increases in size, and the ventromedial prefrontal cortex which manages responses to emotions loses volume (Perry et al., 2018). These areas are affected by hormones, which function and operate differently in women than in men, resulting in studies which explain how hormones and their neurotransmission contribute to gender differences in marked responses to stress (De Carvalho et al., 2016).

People who have experienced childhood abuse have difficulty processing external stimuli and self-regulation due to neurobiological changes that occur in the right hemisphere of the brain during development (Mahajan, 2018). Symptoms of PTSD correlate to the developmental stages in which the individual sustained trauma and of the development of the brain during exposure to trauma, such as early, middle, and late adolescence (Mahajan, 2018). Areas of the brain such as the hippocampus left cerebral cortex, and cerebellar vermis are negatively affected as well as the ability for sensory integration (Mahajan, 2018).

Adverse College Experiences

Sexual victimization of women on college campuses is not new. However, the literature indicates that over 40% of college women report having experienced sexual assault in their lifetimes, and 25% of women reported experiencing sexual abuse of some kind, including rape, within their first year of college. The same study reported that sexual assault accounts for significantly lower GPAs and college retention (National

Sexual Violence Resource Center, 2023; Stermac et al., 2020). Risk factors for female PTSD include chronic poverty, interpersonal abuses, sexualization, and sexual abuse, lack of family or social support, adverse childhood experiences (ACE), vicarious trauma, housing, and employment challenges (ACE Response, 2019; Gilin & Kauffman, 2015). Cross-culturally, 40-50% of female experiences of trauma result in the development of posttraumatic stress responses, and needs are unmet by campus programs. Historically, mental health has been provided as a management tool rather than preventative measures recommended more recently (see Moss et al., 2022).

Suicidal thoughts and behaviors are highest among first-year college students and even higher among first-year college students with histories of emotional abuse and betrayal by caregivers before the age of seventeen (Auerbach et al., 2017). Suicide is also higher in rural areas, although suicide rates due to PTSD symptoms are lower in rural areas than in urban areas (Thorne et al., 2017). Interestingly, although PTSD rates in rural areas don't contribute significantly to suicides, symptoms have been associated with adverse early childhood experiences and college dropout (Gilin & Kauffman, 2015).

College Counseling Centers

Student perception of need is a concept introduced to influence college counseling centers about evaluating their services beyond traditional roles (Resko, 2017). Mental health conditions have no timeframe, yet counseling centers are open during business hours in which students are attending classes. Additionally, stigma regarding mental health may prevent students from reaching out to crisis centers, which triggered fears of risk and misunderstandings (Boyraz & Granda, 2019).

Supports and various models of accommodation exist in higher education for students with autism and intellectual disabilities, veterans with PTSD, refugees, and immigrants with emotional disabilities, foster care alumni, those with physical and developmental disabilities (Boyraz & Granda, 2019). However, none exist for women with PTSD despite indications that challenges exist for this population (Resko, 2017). Reasons for supporting students with the afore-mentioned disabilities is that enough research was conducted to determine the need for these services. Currently, there is not enough research about female college students with PTSD to provide an accurate vision of necessity for program development, although there is research that indicates that there is a substantial population of women in college who underachieve or drop out because they have no support for their symptoms (Mullet et al., 2022).

In some models, creating supportive environments, managing encountered challenges, and negotiating how much to disclose for promoting successful education has informed program considerations (McDonald et al., 2022). In another model prepared for former foster care students building social capital, planned opportunities for campus inclusion, additional financial resources, peer support, flexible housing opportunities, extra advising and childcare, local community partnerships, expanded mental health and wellness services, etc. encouraged success based on research about foster care kids (Salazar et al., 2016).

While college counseling services are usually successful in facilitating positive change, reducing suicidal and self-harm behaviors, and increasing retention in the populations they serve, only a minor portion of students experiencing mental health

problems are evaluated by college mental health professionals (Gulliver et al., 2019). Mental health stigmas, social and economic pressures, and fear of failure prevent students from accessing counseling centers (Gulliver et al., 2019).

Recent research concludes that considering the alarming rate of social and campus violence combined with the chronic issue of college student anxiety and depression, the roles of college counseling centers have shifted from solely providing therapeutic services to also providing outreach, community partnerships, psychoeducational events and more of an overall integrated approach to meet the whole student in their various life roles and circumstances (Francis & Horn, 2017). Furthermore, one study found that students identified systemic issues as barriers to academic success (Sadowski et al., 2018).

Issues identified by low socioeconomic students were “having unmet needs in college to address mental health issues, work/life balance, feeling overwhelmed by assignments, a disconnect between traditional college roles vs. contemporary ones in which students today have greater demands placed on them to work while accruing federal student debt, inadequate orientation training and period, lack of consistency in curriculum across courses, lack of choice about course delivery modes, the shock of leaving traditional lifestyle for the “collegiate” lifestyle, and lack of peer support (Sadowski et al., 2018). This study recommended initiative-taking changes in all categories identified by the students and recognized student appreciation for affordable on-campus counseling, albeit fairly insufficient to meet actual needs.

Additionally, since the 2007 Virginia Tech shooting and other acts of domestic terrorism, college counseling services have shifted from an educational focus on developmental needs to the business of violence prevention and threat assessment teams (Flynn & Heitzmann, 2008). Rather than adhering to advocacy for the emotionally challenged and vulnerable students adjusting to life away from home, colleges administratively aimed to promote campus safety, and without solid focus and planning remained neutral in their abilities to affect profound change in a rapidly changing population of skeptical students familiar with global disasters (Flynn & Heitzmann, 2008).

Although colleges and universities have followed the traditional clinical model, some have been reaching out towards a more comprehensive trend to incorporate individual counseling with community wellness, outreach and community collaborative services, and resiliency models (Brunner et al., 2017). This comprehensive counseling center model (CCC) developed after 2007 as a response to increasing student demands for counseling and wellness services, should not be confused with the integrated counseling model which combines mental health services with physical health services. It is successful in areas where utilized, as it addresses the whole person in the environment at a time in which students are undergoing dramatic personal and professional transformations (Brunner et al., 2017).

Discussion about PTSD and other trauma associated diagnoses in college students elicits a need for trauma-informed wellness centers on campuses. Studies are emerging which explore the relationship between childhood abuse and suicide ideation in young

college students. One study found that female college students who had experienced childhood sexual trauma had more adverse life experiences later in life, as well as an aversion to living more often than those who had not experienced childhood sexual abuse (Thakkar & McCanne, 2000). Notably, emotional intelligence and social support is linked to student success and lowered PTSD symptoms (Hofman et al., 2016).

Role Conflicts

Barriers that female students encounter include role conflicts, which can compound existing trauma symptoms (Thompson-Ebanks, 2017). Being a wife, mother, partner, or caretaker of parents can add more stress to women with the added responsibilities involved in these roles. Many students carry the role of caregivers for their aging parents, as Millennials and GenZ were generally born to older mothers. Studies indicate that women have dropped out of college due to family and work pressures, stigmas about pregnancy, single parenting, sexual assault, and feelings of alienation or lack of supports to remain in college (Khanam et al., 2016). Families of women are often not aware of the supports that female students need in higher education due to the roles expected of them at home, suggesting a need to provide more scholarship and funding opportunities to women, since juggling roles is counterproductive to academic success (Khanam et al., 2016). Pressures to care for family members can interrupt college goals.

Furthermore, as societies embrace independent behaviors of women, and women learn to integrate more independently into patriarchal structures symptoms of PTSD such as high-risk behaviors, social isolation, and disregard for social support can go

unrecognized as simply wanting to be independent, rather than symptoms of a larger problem (Liu et al., 2022). Trauma Awareness and competence are key factors in managing healthy behaviors and overall sense of well-being, affecting areas of social, physical, financial, and academic support. Some findings have asserted that when comprehensive supports are in place, the negative effects of academic adjustment are reduced (Murray, 2013).

Additionally, more college students are managing work, families, and college than in previous decades (Opoku et al., 2023; Ricks & Warren, 2021). Poor working conditions, family conflict, and workplace policies that don't support employees enrolled in college are identified as barriers to success (Ricks & Warren, 2021; Yu Chih et al., 2020). Despite these challenges, some research indicates that students succeed in college to mitigate and overcome obstacles caused by chronic, even generational distress.

Approximately 20% of first-year students do not remain in college past the first year (Bishop, 2016). Reasons include lack of social adjustment, academic habits, and psychological issues, all which can eradicated by competently developed student counseling centers (Bishop, 2016). The study findings were that regardless of counseling sessions attended, low socioeconomic students, and those with lower high school GPAs, or who were minorities had higher dropout rates. However, while Bishop (2016) inferred that these students were less responsive to counseling sessions, the study did not indicate whether or not the interventions addressed this demographic or if they further disconnected them from the mainstream college population. Study findings also did not indicate whether or not the low high school GPAs correlated with socioeconomic status.

Trauma Awareness and Competency

Bishop (2016) concluded that counseling centers have not completed the research necessary to address the needs of college students with financial issues, generational traumas, or differences in social status. Roughly 30% of freshmen college students experience mental illness, primarily since depression during the transition to college is difficult (Thompson-Ebanks, 2017). Stigmas, fear of failure, lack of faculty knowledge about mental illness and rural needs, first-generation and nontraditional student needs, feeling alienated or socially inept due to culturally rural backgrounds, and housing needs voiced by students as requiring additional consideration for success and retention (Thompson-Ebanks, 2017). Close to 20% of students experiencing difficulties in which mental health is a considerable drop out of college because they either don't have the support they need or perceive that they don't (Tamin, 2013). Nationally, schools that do succeed in higher retention are those that have studied and implemented trauma-sensitivity and campus-wide leadership inclusive of activities, housing, employment, and financial considerations (López-Zerón & Parra-Cardona, 2015). Although PTSD is not an intellectual disability, symptoms of illness such as memory deficits, difficulty concentrating, etc. fit into an intellectual disability framework. Creating space to help those with PTSD may be as easy as broadening programs for intellectual disabilities.

An area of expertise about trauma awareness and competency is veteran's programs which often include family and staff support, and activities commensurate with social needs. Although specific to veteran's needs, the VA outreach programs on campuses can collaborate with other developing programs to expand knowledge and

programs to meet the need of female students with PTSD, regardless of veteran status (O'Connor et al., 2018). Although PTSD has gained awareness due to combat veterans returning home with debilitating symptoms over the past fifty or more years, posttraumatic stress disorder transcends all populations. 1 out of 9 women, and 50% of the overall outpatient mental health population are treated for PTSD symptoms (PTSD United, 2022).

As violent incidents continue to escalate and are made known to the public via social media and other forms of technology, trauma-informed therapies have become a priority in healthcare settings. Trauma awareness and competency must be required for our society to recover and flourish. Continuing Education Credits (CEUs) if mental health professionals are to maintain competency in the military, schools, and communities. Illustrating such competency are the emerging and intensive conferences and workshops for healthcare and mental health professionals which include such topics as proactive approaches in violence reduction, effective business leadership models, group therapy focus, risk management considerations, community healing after the tragedy, cultural change education, sleep hygiene and neurobiology, holistic reconceptualizing of trauma, integration of spiritual needs, less emphasis on pharmaceuticals to manage symptoms, boundaries, ethics, and social media considerations, PTSD and trauma recovery workshops for both civilians and military, empowering relationships, innovation and entrepreneurship, geriatric therapies, food and substance education, and other training intended to markedly improve the standard of care nationwide (APNA, 2018). Without such competency, systems fail under the weight

of large social systems which are currently straining under pressures of vast global changes (APNA, 2018; Murkar & De Koninck, 2018).

Gendered definitions of trauma have been described as being continuously degrading to feminine populations (Burstow, 2003; Shalka, 2019). The traditional construct of trauma contradicts another aspect of feminization, as a weakness explained in terms of one's inability to manage oppressive circumstances without engaging in socially unacceptable responses perceived as weakness, helplessness, confusion, and other emotions traditionally associated with patriarchal views (Shalka, 2019). For these reasons, traditionally normal and good responses considered strong, and masculine are preferable to the perceived flawed response of the oppressed (Shalka, 2019). Consistent with the GenZ population Shalka (2019) described gender as being a socially constructed framework with masculine and feminine identification following a continuum. Trauma follows this continuum as well, becoming more prevalent and frightening to individuals as power and privilege is diminished by masculine inheritance. For example, partying and sexual behaviors are historically accepted by colleges and universities as being a normal part of the induction into adulthood. However, as the institution is historically patriarchal, more cisgender, transgender, bisexual, asexual, and other identities on the continuum are adversely affected by traumatic attacks verbally, emotionally, psychologically, sexually, and physically (Shalka, 2019).

Additionally, the topic of power and privilege is neglected by colleges and universities despite playing a large part in administrative decision-making (Shalka, 2019). Although trauma experiences invoke anger, female anger is still not accepted in Western

society. Historically, the dominant Western cultural norms have ignored and often condemned the anger of oppressed Indigenous cultures, opting only to accept the romanticized sadness, victimization, and vulnerabilities of traumatized populations (Shalka, 2019).

Summary and Conclusions

PTSD is prevalent in the United States, and more than half of the population experiencing symptoms are women (PTSD United, 2022). Approximately 17% of college students in the U.S. report having PTSD symptoms, yet there is no standard protocol to address it at the college level (Lee, 2018). Up to 84% of students report Adverse Childhood Experiences, PTSD symptoms, and significant difficulty managing emotions and behaviors (O'Bryan et al., 2015). Literature I reviewed implied a need for practice, policy, and research in colleges to address trauma-related stressors of students experiencing symptoms that interfere with academic success (Roebuck et al., 2023). While PTSD transcends genders and ethnicities, female students will be the focus of this study for focus and clarity.

Campus violence and changing sociopolitical climates bring issues of mental health, trauma awareness, and trauma treatment competency to the forefront. For example, in Idaho colleges and universities these problems are rarely addressed except during random demonstrations or counseling appointment hours. As increasing numbers of students with PTSD and other mental illnesses enter higher education, this research explored the experiences of female college students in Idaho to better understand the strengths and barriers they face, and the needs they define for their success.

Trauma alone is identified as producing a disadvantaged identity associated with oppression, low socioeconomic status, weakness often associated with feminized populations, and academically divisive (Shalka, 2019). Furthermore, trauma has become a household term since 9-11, a point in time that shaped our latest generation's worldviews during a twenty-year period in which they have not known a life without war. In subsequent chapters I expand on emerging research regarding biological, socioeconomic, and environmental factors contributing to PTSD in women that until recently has been lacking in scientific literature.

I reviewed over sixty sources covering the topics of mental illness in colleges and universities, female experiences of trauma and PTSD symptoms, adverse childhood experiences, addictions, shame and trauma theories, the nature and expressions of PTSD, and college student retention. Encouragingly, despite the lack of research available about trauma and college dropout when I began my review there have been recent studies emerging about the effects of trauma and relation to college retention and dropout. What I did not find in my searches was information about female college students identifying trauma experiences as influencing their college outcomes.

As our political climate changes significantly in the last decade and may continue to change in unexpected ways, learning about and addressing the contemporary needs of female students is important. In an environment in which two of the youngest generations merging (Millennials and GenZ) comprise 75% of the U.S. workforce by 2025, it makes sense to try to understand what drives their ambitions, what their challenges are, and how

to encourage the best of their abilities to sustain our society economically, environmentally, socially, and politically (McMahon & Bernard, 2019).

The gap in the literature was that I found no information addressing the experiences and retention of female college students with PTSD. There is a large body of growing literature about PTSD and other trauma diagnoses in society, colleges, and universities, as well as information about the efficacy of wellness centers, trauma-informed therapies, emerging needs of the youngest generations entering college. Fortunately, researchers agree that therapeutic interventions are successful in treating PTSD symptoms and "re-wiring" the brain (Mahajan, 2018; Mate, 2022; Nunez et al., 2022; Perry et al., 2018; Van der Kolk, 2022). The findings from this basic qualitative study serve to inform academia about the nature and experiences of female students with PTSD and implications for strengthening the college programs and supports to strengthen retention of female students with PTSD. In Chapter 3, I review the rationale for the research design, role of the researcher, participant selection, instrumentation, data collection, data analysis and I provide a chapter summary.

Chapter 3: Research Method

The purpose of this basic qualitative study was to explore the experiences, beliefs, perceptions, attitudes, and needs of female college students with PTSD, and what they identify will guide them towards successful graduation. This chapter presents a review of the purpose and research questions, the research methodology used to explore participants' experiences, the background and current circumstances related to the study, the role of the researcher as the interviewer, bracketing of researcher experience, measures taken to protect participants, and data collection and analysis procedures.

Research Design and Rationale

The most relevant methodology to explore the experiences, beliefs, and perceptions that shape the experiences of female college students with PTSD is in the form of a qualitative study. Creswell (2013) recommended qualitative design when searching for meaning and understanding of complex phenomena amongst individuals and groups. Crabtree and Miller (2022) noted that qualitative methods are used to explore behaviors, perceptions, and the interconnectedness of varied experiences. Originally, I considered phenomenology and included both interviews and focus groups as data collection tools. In a phenomenology study, researchers explore lived experience and how it presents itself in the individual (Merriam & Tisdell, 2016; Yin, 2018). However, a phenomenology study design can be time consuming and labor intensive (see Yin, 2018). Further, as the work progressed and COVID restricted my movement, it became apparent that I would not be able to include focus groups in addition to interviews as part of my study; therefore, I determined that the approach was not the best match for this study. In

considering a qualitative case study approach, a researcher explores a phenomenon through several cases that are bound in some manner (Yin, 2018). In this study, I was not focused on a local setting, such as a specific university, or state; thus, I determined that the case study would not be the most appropriate match for this study. Because of the nature of this study, I determined that a basic qualitative approach was most appropriate for this study. Using basic qualitative inquiry was consistent with the strategy of naturalistic inquiry, which involves studying real-world experiences as they present themselves naturally (Merriam & Tisdell, 2016; Patton, 2014). Basic qualitative research is appropriate in exploring participants' experiences and helpful in delving into the underlying meaning of participants' experiences. Basic qualitative tradition allows the researcher to approach the inquiry with a holistic, empathic, social, and environmental context. Lim (2011) stated that basic qualitative research is useful to generate rich descriptions of the phenomenon being studied. The kind of qualitative data used to learn about and explore the lived experiences of participants may be gathered through semistructured interviews.

The research questions for the study were as follows:

RQ1: How do college females with PTSD describe their academic and social experiences in terms of degree completion?

RQ2: What types of assistance do college female students with PTSD feel is needed to improve their college success?

Central concepts of the study involved exploring the needs of female college students with PTSD symptoms regarding completing their college educations, to explore

their relationships with academic norms, success versus failure or perceived failure, and ways in which they coped with and managed trauma symptoms while enrolled in higher education.

Role of the Researcher

My role as a researcher was as interviewer, transcriber, and coder. I collected and recorded the experiences and perceptions of female college students, transcribed interviews with them verbatim, and extracted themes from the interviews to inform college counseling and wellness programs about services and conditions that female college students with PTSD would like to have to perform successfully in college. Success is defined as graduation from a 4-year college or university. Using a list of 10 interview questions that I developed, I asked women who struggled with PTSD symptoms to explain their experiences in college individually, by using a semistructured interview as well as probing questions to follow up and to gather deeper information from the participants.

As previously mentioned, I bracketed my perceptions, as I had a history of trauma, had been diagnosed with PTSD, had navigated successfully through bachelor's and master’s programs, and was now working on completing my PhD. I separated my own experiences, perceptions, and biases by using a daily journal to document my understandings and create boundaries between myself and the participants. Using a reflective journaling process to bracket personal experience, interpret and analyze data, and evoke creativity is important in developing the practice of conceptualizing and synthesizing data as well as keeping the creative mind sharp (see Janesick, 2011).

Methodology

Participant Selection Logic

Participant Population and Sampling Strategy

The study participants were female college students who were diagnosed with PTSD, CPTSD, or another trauma-related diagnosis and had some treatment background. This population of participants had experiences with trauma and college and could furnish information on academic experiences, social experiences, and assistance in terms of degree completion and college success. This study was seeking to gain a deeper understanding of this population's experiences in the college environment to address the gap in the literature related to supporting female students with the specified diagnosis in terms of completing their university degree program.

Purposeful sampling is used in qualitative research to identify participants who are knowledgeable of the phenomenon being studied. Including participants who are specifically knowledgeable or experienced with a topic of interest supports the depth of understanding of the phenomenon being studied (Bernard, 2002). Criterion sampling, a form of purposive sampling, is used in qualitative research to focus on characteristics of the attributes selected so that the researcher may form perspectives on the sample identified (Creswell & Plano Clark, 2011). Specifically, "criterion sampling involves selecting cases that meet some predetermined criterion of importance" (Patton, 2014, p. 238).

Selection Criteria

Criteria were used to select the participants for this study. The inclusion criteria for participants included that the participants identified as female, were over 18 years of age, were enrolled in a 4-year college or university degree program, and self-identified as being diagnosed with PTSD, CPTSD, or a trauma-related diagnosis and had some treatment background.

A sample of nine participants was selected using criterion sampling to include only those who self-identified as having been diagnosed with and treated for PTSD, CPTSD, or trauma-related diagnosis with at least some treatment background based on the recruitment flyer and responded indicating an interest in participating in this study. Participant inclusion criteria were included in the participant consent form and confirmed before conducting the interview using the iPhone app TapeACall. I recruited potential participants through Facebook and LinkedIn and through a participant pool of willing research volunteers by posting an electronic invitation for the study. Participants self-selected into this study after reading the electronic invitation and contacted me via my Walden University email to indicate their interest in the study. I responded by email and sent them the consent form. I asked each participant to review the consent form, and if they agreed, to respond to me in an email saying, “I consent.” Once I received the reply regarding the consent from the potential participant, I arranged a time to conduct the interview.

Procedures for Identification and Recruitment

After Institutional Review Board (IRB) approval, I recruited potential participants through Facebook and LinkedIn, and through a participant pool of willing research volunteers by posting an electronic invitation for the study. Participants self-selected into this study after reading the electronic invitation and contacted me via my Walden University email to indicate their interest in the study. I responded by email and sent them the consent form. I asked the participant to review the consent form, and if they agreed, to respond to me in an email saying, "I consent." Once I received the reply regarding the consent from the potential participant, I arranged a time to conduct the interview. After approximately 3 months of posting invitations, I recruited nine participants who self-selected to be interviewed for my study.

Saturation and Sample Size

Saturation is important to qualitative research and can be determined in various ways. Saturation is determined to be complete when the data collected repeat themselves and do not result in the identification of new information to inform the research questions. Saturation is an indication of quality in qualitative research (Mason, 2010). In qualitative research, the goal is to thoroughly explore the phenomenon being studied as a means to demonstrate depth rather than obtaining a specific number of participants (Fossey et al., 2002). Thematic or data saturation refers to the notion of collecting data until no additional patterns emerge (Green & Thorogood, 2018). I determined saturation to be complete when the data collected repeated themselves and did not produce new patterns from the information collected.

Sample size is a critical focus in qualitive research. Hennink and Kaiser (2022) noted that a sample size of nine to 17 was appropriate to reach saturation. Morse et al. (2002) noted samples consisting of participants who represented the topic of the research product information reflective of the depth of data collected, thereby supporting the sufficiency of the sample. Although I aimed for eight to 16 participants, I discontinued interviewing participants at a total of nine interviews, as I was able to reach saturation of the interview data based on the similarity of responses I obtained from the nine participants (see Saunders et al., 2017).

Instrumentation

Interviews are a means of data collection for qualitative research. I conducted semistructured interviews with probes using a researcher-designed protocol to collect data for this study. Semistructured interviews are designed to allow the researcher to follow a predetermined list of questions and explore the participant's responses pertaining to the phenomenon that is the focus of the study as the researcher deems is appropriate (see Crabtree & Miller, 2022). As the researcher, I was the primary data collection instrument for this study. I used the interview protocol with probes to solicit participants' description of their experiences and needs related to services (see Turner, 2010). Probes are used in semistructured interviews to allow the participant to expand their response to support the collection of rich data (see Creswell, 2013; Turner, 2010). I maintained a systematic interview protocol process and practice throughout the interview to support the integrity of the data collection. In my role as researcher, it is critical to be

conscious of using a consistent and systematic approach to each interview (see Berger, 2015; Elo & Kyngas, 2008; Phillippi & Lauderdale, 2018).

I developed and aligned interview questions to the research questions, which supported the content validity of the interview protocol (see Ravitch & Carl, 2019). Feminist trauma theory concepts were used to inform the interview questions, by using questions open for participants' interpretation of their experiences (see Wilkin & Hillock, 2014). Additionally, I paired interview questions with the appropriate research questions to ensure sufficiency of data in answering the research questions and addressing the purpose of the study. I ensured that the interview questions were aligned to the research questions that guided this study. I obtained feedback regarding the clarity of the interview questions from my doctoral committee, which included professors who are methodologists, and I made the appropriate changes. Gaining input from experts in the field such as methodologists supported the creation of an interview protocol that aligned with the phenomenon being studied and supported content validity (see Ravitch & Carl, 2019). The interview protocol I used was most appropriate to establish and maintain credibility and the feminist trauma-informed conceptual framework in which empowerment of voice and collaboration are encouraged (see Creswell, 2013; Pemberton & Loeb, 2020; Ravitch & Carl, 2019; Yin, 2018).

Content validity was established through the development of a researcher-designed protocol using the conceptual framework, literature, and my doctoral committee methodology experts (see Nikolopoulou, 2022). I developed an interview protocol using

10 open-ended questions, including a final probe, “Is there anything else you would like to add?” I was able to gather sufficient data to reach saturation and answer the questions.

After interviewing and transcribing the interviews, I color- and hand-coded each one to identify similar statements until I had enough to add to pivot tables to observe frequencies of codes and categories and to examine the association between the open and a priori coding, a process referred to as *triangulation* (see Jick, 1979). I kept a separate journal to collect my own thoughts about the data collection process, my observations, and feelings about assumptions, and to distinguish participant comments that stood out to me (see Fischer, 2009).

Procedures for Recruitment, Participation, and Data Collection

The target number of participants was eight to 16, and a total of nine participants were recruited. Once I had received Walden IRB approval (#12-18-20-0353101), I recruited participants through Facebook, LinkedIn, and a participant pool of willing research volunteers using the IRB-approved recruitment flyer. I recruited participants for semistructured audiotaped interviews who identified as female, were over 18 years of age, were enrolled in a 4-year college or university degree program, and self-identified as being diagnosed with PTSD, CPTSD, or a trauma-related diagnosis and had some treatment background.

Participants self-selected into this study after reading the electronic invitation and contacted me via my Walden university email to indicate their interest in the study. I responded by email and sent them the consent form. I asked the participant to review the

consent form, and if they agreed to respond to me saying, “I consent.” I arranged the interviews once I received the participant’s email acknowledging their consent.

Data collection occurred over a period of 3 months. The data collected were obtained via recorded telephone interviews. Thirty to 60 minutes were allotted for each interview. I collected nine interviews, ranging in length from 13 minutes to 46 minutes. The average interview length was 27 minutes. Interviews were recorded and transcribed using the app TapeACall. Once interviews were completed, participants were thanked. After the initial recruitment process, data collection was an ongoing interpretive process until the research responses were saturated. I followed up with the participants by sharing the draft findings of my data analysis.

Data Analysis Plan

Once I recorded and transcribed interviews, I proceeded to construct meaning from the data, using a process of content analysis and Yin’s five-step method of data analysis, which includes compiling, disassembling, reassembling, interpreting, and concluding (Bengtsson, 2016; Saldana, 2021; Yin, 2018). My data analysis strategy was to record and transcribe interviews verbatim to ensure accuracy, as well as engaging in daily reflexive journaling practice to clarify my personal bias and analyze any assumptions I may have had during the interview-gathering process. During this process, I looked for codes, categories, and themes related to trauma theory, compared with feminist trauma theory, and relevant to the research questions. Data were coded by hand into emerging codes, categories, and themes. I used a combination of color coding with

highlighters by hand, transferring to an Excel spreadsheet and using a combination of color coding, categorizing, and developing into themes.

I used open descriptive coding, an inductive coding process, for my first two rounds, which resulted in finding 16 descriptive codes that related to the research questions. I then used a priori coding, a deductive process, to compare to the conceptual framework, using operational definitions from feminist trauma theory to the information obtained from the transcripts. Using the pivot table, Excel spreadsheet, tables, and diagrams, I was able to examine patterns and similarities between the open and a priori coding (Johnson & Christensen, 2020). In making meaning of the data, resulting data emerged as categories and themes that resulted in two primary themes that answered the research questions, and no remarkable differences in participant responses emerged.

Issues of Trustworthiness

Trustworthiness in population sample was to clearly explain the purpose of the study, protect identities of participants, provide documents involving assurance of confidentiality and privacy, protection from pressure to participate or to maintain participation if symptoms escalate due to interview processes, and provide interview questions before gaining permission to interview from participants. Trustworthiness in gathering and coding data was to provide initial information stating that I would transcribe interviews verbatim and analyze manually.

After obtaining consent from participants, validity for data collection was ensured by using audio recording for all interviews and transcribing verbatim. All interviews were collected using a 10-question, semistructured interview guide to provide consistency

between participant responses. The interview questions were transcribed verbatim and saved on a password protected personal laptop. The text excerpts were copied and pasted into an Excel spreadsheet for data management and analysis. Pivot tables were used to conduct content analysis of the coded information from the interviews.

Credibility

Credibility refers to the researcher assuring that the participant stories will be consistent with the study's goals to reconstruct and interpret (Patton, 2014). I transcribed, categorized, analyzed, and coded with the intention of remaining with the study's goals (see Yin, 2018). Using the semistructured interview I aligned with the research questions, I maintained confidentiality by using codes to identify participants rather than using names and did not collect any demographics. Saturation was determined when responses had answered the research questions and interviews ceased producing added information (Fusch & Ness, 2015). Additionally, I triangulated the data through using different types of coding approaches (see Jick, 1979) and also by comparing coded information from different data sources, such as hand coding conducted by a peer review, the spreadsheet, transcripts, and my researcher's journal (see Flick et al., 2012; Janesick, 2011; Jick, 1979). I also conducted member checking by sharing a draft of the findings with the participants and asked them for any input, or edits (see Janesick, 2011).

Transferability

Transferability refers to the researcher's responsibility to explain gathered data in such a way as to provide information for further research about the studied topic Bengtsson, 2016). I coded with the intent of responding to the research questions as well

as being aware of any themes which may have offered insight for future research. The explanation of the data aligned to the conceptual framework, feminist trauma theory, allowing for participants to share their experiences through a reflective and empowering, validating process (see Wilkin & Hillock, 2014).

Dependability

Dependability requires that the inquiry process is logical, traceable, and documented. To establish dependability, I followed qualitative research practices by maintaining a transparent audit trail (see Carcary, 2020). I saved all documents used for the interview, management, and analysis process on a password protected personal laptop. I maintained a reflective journal throughout the research process to bracket my experiences, feelings, and thoughts about the data, adjusting codes, labeling, and relabeling data as necessary (see Janesick, 2011). I ensured that the data coded were pertinent to the research questions and aligned with the conceptual framework, feminist trauma theory (see Wilkin & Hillock, 2014). Participants engaged in member checking, by reviewing a draft of the study findings and were invited to share their insights or feedback on my interpretation of the information.

Confirmability

Confirmability links assertions, findings, and interpretations to the collected data and research questions (see Amin et al., 2020). The coding process linked all findings to the study's research questions. Reflexivity included researcher note-taking, evaluating and re-evaluating participant responses against the research questions and consulting with

mentors, committee members, and advisors throughout the data analysis process (see Janesick, 2011).

Intra-coder reliability refers to the means of checks and balances, or measurement of stability and lack of coder bias in data analysis. I asked one professional colleague who was unfamiliar with the study to code an interview to compare with my coding responses to ensure that the coding was sound and obtained a signed confidentiality agreement from her (see Rodríguez-Morejón et al., 2018).

Ethical Procedures

Before proceeding with the study, I submitted an application and was approved by the Walden University IRB to proceed (IRB Approval #12-18-20-0353101). The Consent form was a key document in ensuring that participants were aware of the purpose of the study, procedures I used in this study, and the consent form also included information about participants' rights, and how their confidentiality would be protected. Per the recruitment flyer, participant names were not collected or stored. After participants responded to the posted recruitment invitations indicating their interest in the study, I e-mailed them the Consent form to them and requested that they reply by stating "I Consent," if they were interested in participating in this study. Next, I set a date and time to conduct the interview that was agreeable to the participant.

I had no prior or current relationships or knowledge of participants and assigned each participant a number to protect their confidentiality. I will securely maintain the data for no less than 5 years per Walden University IRB guidelines. As the sole researcher for the study, all information regarding the study is kept locked in a password protected

laptop and only shared with Walden University IRB and committee members upon request.

Summary

In this chapter, I explained how I decided upon the qualitative method of research, developed my interview protocol to learn about the experiences of female college student with PTSD, and how I obtained permission from the IRB. I described how I recruited participants, conducted interviews, transcribed, and analyzed data. Additionally, I described how I dealt with ethical procedures and issues of trustworthiness. Each participant responded to the same 10 interview questions to describe how their beliefs, perceptions, and attitudes affected their academic and social experiences in terms of degree completion and how college assistance affected their success. In Chapter 4, I describe the data analysis process and findings.

Chapter 4: Results

Introduction

The purpose of this qualitative study was to explore the experiences, beliefs, perceptions, attitudes, and needs of female college students with PTSD and what they identify will guide them towards successful graduation. I drew from a curious perspective, given that few studies exist about civilian women and their various PTSD experiences, while many exist about combat-related PTSD. The study findings can provide material for further study and inform stakeholders regarding policies and programs for female college students with PTSD. The conceptual framework, feminist trauma theory, differs from other trauma theories in the assumption that personal connection and empowerment enable individuals to make sense and meaning of their experiences within the context of female experience rather than historically colonial male interpretations (Moore, 2017; Thompson, 2021). The data analysis approach used feminist trauma theory as a basis for gendered understanding of institutionalized and social discrimination, while keeping in mind the lived content of participant experience as it pertains to the theory (see Moore, 2017; Thompson, 2021; Wilkin & Hillock, 2014). In this chapter, I explain demographics, data collection, conditions during the interview process, and the analysis process, and I review evidence of trustworthiness and the study results. I describe the codes, categories, and themes that emerged from the information collected via nine semistructured interviews with female college students with PTSD. Although previous studies have explored mental health and wellness of various college student populations, including those with military and combat traumas and PTSD, I found

none that explored the experiences, perceptions, attitudes, beliefs, or academic support systems provided for female college students with PTSD. There are few qualitative accounts of female college students with PTSD and their experiences, needs, and identified supports in university undergraduate programs. Therefore, the gap in literature supported the impetus for this study.

The interview approach was relaxed, informal, and intended to obtain a verbal account of each participant's experiences. Participants were acquired through a pool of willing research volunteers via Facebook and LinkedIn. Participants responded to an interview protocol that I developed using open-ended questions that were based on the conceptual framework, feminist trauma theory. The 10-question interview protocol aligned with the study research questions. I used these questions and probes to obtain a deep understanding of participants' experiences, reach saturation, and answer the research questions used to guide this basic qualitative study (Fusch & Ness, 2015; O'Reilly & Parker, 2012; Walker, 2012). I conducted qualitative data analysis using content analysis and identified codes, categories, and themes (see Bengtsson, 2016; Downe-Wamboldt, 1992) .

This basic qualitative research focused on two research questions to determine how participants described their experiences with PTSD in higher education, and what they expressed needing to improve their success in college. The research questions were as follows:

RQ1: How do college females with PTSD describe their academic and social experiences in terms of degree completion?

RQ2: What types of assistance do college female students with PTSD feel is needed to improve their college success?

In this chapter, I describe the setting, participant demographics, data collection, and data analysis for this study. I explain the results of data collection from the interviews in relation to the research questions and trustworthiness. I conclude by providing a summary.

Setting

Due to COVID-19 conditions and restrictions, the interview setting was via telephone using TapeACall to record and transcribe calls. I recruited participants nationally using Facebook and LinkedIn. Once participants responded to Facebook and LinkedIn invitations, I set telephone appointments with them at their convenience. The semistructured interviews were conducted using the researcher developed nine-question protocol. I developed the interview questions to align with the research questions. Of the nine women who elected to be interviewed, all completed the interviews by answering every interview question. All participants reported interviewing from their homes, and interviews lasted no longer than 1 hour.

Demographics

Nine participants volunteered for the study. Eight of the students were enrolled in a master's program, and one had graduated with a bachelor's degree within the past 5 years. All identified as having been diagnosed with PTSD while in college. All participants stated that they had "dropped out" of college to learn how to manage their symptoms before returning to complete their degrees.

Participants identified as being from various parts of the United States, and all had completed a bachelor's degree prior to the interview. All participants met the criteria for the study. I did not collect race, ethnicity, or age, though all referred to themselves as having dropped out of college at some point in their process before continuing to completion. Of the nine participants, all identified as having changed their degree majors after being identified with PTSD to the social sciences and psychology. Table 1 reflects the participant demographics, including the number of times each participant dropped out, number of misdiagnoses, number of years required to complete undergraduate degree, degree status, and major.

Table 1

Participant Demographics

Participant	# of times dropped out	# of misdiagnoses	# of years to bachelor's completion	Degree status	Degree major
P1	Multiple	1	20	Bachelor/3rd-year master	Unknown
P2	1	Unknown	5	Bachelor/Completing master	Forensic psychology
P3	0	Unknown	Unknown	Bachelor/Completing master	Anthropology
P4	0	Multiple	Unknown	Bachelor/Master/Completing PhD	Forensic psychology
P5	1	1	4	Bachelor/Completing master	Sociology
P6	0	2	4	Bachelor/Completing master	Unknown
P7	1	Unknown	15	Bachelor	Social work
P8	1	2	6	Bachelor	Youth ministry
P9	Unknown	Unknown	4	Bachelor/Completing master	Psychology

Data Collection

Once I obtained Walden IRB approval, I posted the approved recruitment flyer to Facebook, LinkedIn, and a research participant pool. After 12 weeks, nine participants self-selected into the study who met the participant criteria. I scheduled the audiotaped interviews at a time convenient for each participant. I conducted one-on-one semistructured interviews with nine participants using a researcher-developed interview protocol with open-ended questions.

The development and alignment of interview questions related to the research questions supported the content validity of the self-developed interview protocol (Ravitch & Carl, 2019). Key concepts from feminist trauma theory (Wilkin & Hillock, 2014) were used to formulate the interview protocol questions. I obtained feedback regarding the clarity of the interview questions from my doctoral committee and made the appropriate changes. Gaining input from experts in the field such as methodologists supported the creation of an interview protocol that aligned with the phenomenon being studied and supported content validity (see Ravitch & Carl, 2019). Interview Questions 1 and 3 solicited information from participants related to both RQ1 and RQ2. Table 2 reflects the correlation of each interview question to the aligned research question.

Table 2

Research and Correlating Interview Questions

Research question	Interview question
RQ1: How do college females with PTSD describe their academic and social experiences?	1. Tell me about how your experiences in college were impacted by PTSD. 2. Describe some successes you have experienced while in college. 3. Describe some challenges you have experienced while in college. 7. What strengths do you bring to your college experience? 8. What weaknesses do you bring to your college experience?
RQ2: What type of assistance do college female students with PTSD feel is needed to improve their college success?	1. Tell me about how your experiences in college were impacted by PTSD. 3. Describe some challenges you have experienced while in college. 4. Tell me how your experiences with trauma are/were met by academic supports. 5. Give examples of how your institution offered assistance to meet the needs of students with PTSD. 6. Tell me about ideas, programs, or other support systems in college that were helpful. 9. What barriers did you encounter as a student that may be related to PTSD? 10. Is there anything else you would like to add?

I recorded data using the iPhone App TapeACall, and then transcribed each interview by hand. I verified that the transcriptions were accurate by listening to the audio-recording and reading the transcription simultaneously multiple times. The length of the interviews ranged from 13 minutes to 46 minutes. Although 30-60 minutes were allotted for each interview, participants spoke rapidly and covered a lot of material in a short period of time, which is common with PTSD (see Fernández-Lansac & Crespo, 2015). Table 3 reflects the interview length for each participant.

Table 3

Length of Interview by Participant

Participant	Length of Interview
P1	19 minutes
P2	22 minutes
P3	31 minutes
P4	37 minutes
P5	25 minutes
P6	19 minutes
P7	29 minutes
P8	46 minutes
P9	14 minutes

I asked each participant the same set of questions using probes to support the participant's description of their experiences and needs related to services (Turner, 2010). Probes are used in open-ended interviews to follow up and allow the participant to expand their response and provide additional information to support the collection of rich data (see Creswell, 2013; Turner, 2010). Following a systematic interview protocol process and practice before, during, and after the interview supported the integrity of the data collection, as I was the primary data collection instrument. As the instrument of data

collection, I acknowledged my role as researcher, understanding that assessment following each interview was critical to refine my approach and be conscious of using a consistent and systematic approach to each interview (see Berger, 2015; Elo & Kyngas, 2008; Phillippi & Lauderdale, 2018). I explained the purpose of the study at the outset of the interview and reminded the participant of their rights regarding taking a break, choosing not to answer a question, and being able to withdraw from the study at any time as they desired. I kept a researcher's journal and employed reflective bracketing to set aside any preconceived notions or biases related to the phenomenon being studied or to participant responses. Bracketing is both identifying and setting aside researcher assumptions as well as using an iterative process of emerging knowledge on a topic already known to the researcher (Fischer, 2009). Reflexivity refers to the ongoing understanding and collaborative making of meaning between data and researcher experience (Fischer, 2009). I used reflexive bracketing to set my own experiences and professional knowledge of PTSD aside while learning from the data, and field notes to distinguish participant experiences from my own assumptions (Fischer, 2009). For example, I wrote in my journal before and after interviews to reflect on and identify bias, e.g., "trauma changed my life, sense of who I am, changed perception" vs. "them?" to differentiate between my reality and that of the participants, and I continued extensively journaling to maintain ethical integrity of the data (see Phillippi & Lauderdale, 2018).

Following each interview, I transcribed each audio recording within 48 hours and saved the audio file on a password-protected file to my computer. Data will remain on my password-protected computer file for a period of 5 years, at which time I will delete and

destroy all files and recordings per Walden University IRB guidelines. No unusual circumstances were encountered while collecting data aside from COVID conditions, which most participants reported as having contributed to their stressors involving either having to work and study remotely or having to work more than usual under trying conditions while also enrolled in college. There were no variations or unusual circumstances in data collection that were not previously discussed in Chapter 3.

Data Analysis

I began the process of coding by listening to the recorded interviews, transcribing interviews, and reviewing each transcript for accuracy against the audio recording of each participant interview. Interviews ranged from 13 minutes to 46 minutes. The average interview length was 27 minutes. Participants spoke rapidly and covered a lot of material in a short period of time, which is common with PTSD (see Fernández-Lansac & Crespo, 2015). Data analysis involves the process of making meaning of the information collected (Saldana, 2021). I used Yin's (2018) five-step process, which included (a) compiling, (b) disassembling, (c) reassembling, (d) interpreting, and (e) concluding. I used a content analysis approach to analyze the data (see Bengtsson, 2016).

Coding Strategy

Compiling Data

I developed nine semistructured interview questions that related to the two research questions identified. I began compiling the data by first transcribing each recording to a Word document for each individual participant, and then I printed the interview transcription. I read and reread the transcript and became familiar with the

interview document and overall experiences and descriptions of the participant's responses (see Bengtsson, 2016). I used colored highlighters to hand-code words, phrases, and paragraphs in each transcription. Saldana (2021) noted that the analysis process involves making meaning of the data by coding, categorizing, and theming the data.

Disassembling

According to Merriam and Tisdell (2016), the iterative process of shaping data to the problem statement and research questions begins during the interview process and continues throughout the entire process of data analysis. Therefore, using content analysis, I began to develop decisions about what aspects of the interviews I wanted to focus on that related to the research questions and focused on areas of the responses that related to my problem statement, which questioned the experiences of female college students with PTSD in higher education and how their needs were or were not addressed in terms of degree completion. I used both inductive and deductive coding, as Bengtsson (2016) noted that qualitative content analysis is an organic process of inductive and deductive coding. In the coding process, I decontextualized the data through the content qualitative analysis process by identifying codes, categories, and emerging themes (Bengtsson, 2016). I initially hand-coded the transcripts using different colored highlighters. As I coded the text, I kept the research questions and purpose of the study in mind, and I highlighted words and phrases that related to each research question. I then entered raw data highlighted in the interview transcriptions into an Excel spreadsheet. For the first round of coding, I used open coding and inductive coding and identified 16

descriptive codes that reflected the description of the experiences reported by participants related to RQ1 and RQ2. I conducted a second round of open coding and examined the Round 1 inductive code for commonalities to identify codes that represented the intended meaning of the participants. In Round 2 of inductive coding, I collapsed the Round 1 codes that were similar and identified nine total codes for Round 2 of open coding. I used the pivot table in the Excel spreadsheet to examine the Round 1 codes to make deeper meaning of the data in Round 2 of the coding process. I derived Round 2 coding by examining Round 1 open descriptive coding for similarities and patterns in the codes that I assigned to the text from the transcripts. Table 3 displays Round 1 and Round 2 coding that reflects the descriptive codes identified to convey the participants' descriptions of their experiences. Table 4 reflects a sampling of the text excerpts from participants with the corresponding Round 2 descriptive codes.

Table 4

Round 1 to Round 2 Open Coding and Descriptive Codes

Round 1 open codes	Round 2 open codes
Academic challenge External challenge Internal challenge Needed resources Negative self-messaging Personal challenge	Barrier/Success
Coping skill External support	Community assistance
External support	Family support
Academic support External challenge Needed resource	Institutional assistance

Behavioral symptom External challenge Internal challenge Negative self-messaging Personal challenge	Social/Behavioral
Emotional challenge Emotional symptom External challenge Internal challenge Negative self-messaging	Social/Emotional
Academic challenge External challenge External support Internal challenge Needed resource	Suggestions/Improvement
Coping skill Personal strength Positive self-messaging Resiliency Trauma incidents reported severe/overcome w/thrive/survive mentality	Thrive/Survive mindset
Internal challenge	Emotions affecting graduation

Table 5

Sample of Text Excerpts Using Descriptive Coding

Participant	Interview text excerpt	2nd round coding
P1	… my high anxiety levels…. I was also diagnosed with panic disorder because of the PTSD…. the stress and the anxiety of attending school and feeling overwhelmed by it.	Social/Emotional
P2	It kind of took my traumatic event to kind of shake me up a bit and probably that meant what field I am currently going after….	Thrive/Survive mindset
P3	….when I was struggling with PTSD or anything and I wasn't being able to accomplish to the same level I was before, I like fell on this negative feedback loop, which, like, made me even more depressed about myself and put me further down the pit…. I think that trauma was a strength.	Social/Behavioral
P4	I've experienced a ton of more trauma. I have a lot of physical issues. I've almost died twice. I've been	Barrier/Success

	through two more sexual assaults. I had a significant other kill himself. I've been in a psychiatric unit once. I've been divorced.	
P5	My first semester I ended up dropping out because it just got so bad…. I haven't really made any friends since my freshman year of college just because of how much anxiety I have about socializing.	Behaviors affect graduation
P6	….having trauma training across the board for all the teachers would be would definitely be amazing…. I think a willingness of the administration to be able to work with a disability service…. otherwise, the students are just gonna drop out because they don't feel like they're supported.	Institutional assistance
P7	I have a therapist that I've started seeing outside of school.	Community assistance
P8	I was told was pretty much like, just shut up and don't say a word about this. So, I didn't really tell anyone about anything until I was college…. this counselor was very odd. He was convinced I was bipolar.	Barrier/Success
P9	….a Christian college and it allowed me not to be in the like rape and sexual assault group because I would be too triggering for me.	Emotions affecting graduation

After completing Round 2 of the open coding, I conducted a priori coding, a form of deductive coding, using feminist trauma theory that served as the conceptual framework for this basic qualitative study. I identified constructs associated with feminist trauma theory and operationally defined those words prior to conducting the coding. The preidentified deductive codes and the operational definitions are reflected in Table 5.

Table 6

A Priori Codes Derived From Feminist Trauma Theory

A priori code	Operational definition
Colonial diagnoses reduce socio-political condition to biological maladaptation	PTSD identified by military and Euro-American imperial interests as a psychiatric abnormality rather than a normal, consequential horror response to assault on the neurobiological system that threatens life worldview (Thompson, 2021).

Identifying and processing experiences in safe environment allows person to partner in treatment	Clinicians can create safety for survivors by approaching them with acceptance, validation, belief in their experiences, and having a non-judgmental stance that can otherwise further a survivors' feelings of guilt and shame….treatment goals are driven by the client, not imposed by the therapist; feminist therapists work in collaboration to build the therapeutic relationship. (Pemberton & Loeb, 2020)
Self-determination, self-efficacy	Self-determination is respecting, promoting, and assisting others in their efforts to identify and clarify their goals (NASW, 2023); positive self-efficacy is the foundation of human motivation, well-being, and personal accomplishments, and the most determinant factor towards positive self-development because it contradicts the sense of helplessness (Bandura, 1977; Bandura, 2001; Everly et al., 2004)
Trust, transparency, safety, egalitarianism	In feminist trauma theory these are necessary qualities in the healing process (Pemberton & Loeb, 2020)
Pathologizing symptoms- fight, flight, freeze, fawn	Trauma in women is often misdiagnosed as personality disorders, therefore pathologizing PTSD symptoms which include fight, flight, freeze, and fawn symptoms (Powell, 2019; Brosnan-Watters, 2021; .

I used the same process of reading the transcripts and highlighting text excerpts to continue the coding process. I used the predetermined deductive codes associated with feminist trauma theory. Table 6 illustrates a sampling of the text excerpts of the a priori codes I derived from the interviews. I identified the a priori codes from the conceptual framework of feminist trauma theory.

Table 7

Sample of Text Excerpts Using A Priori Coding

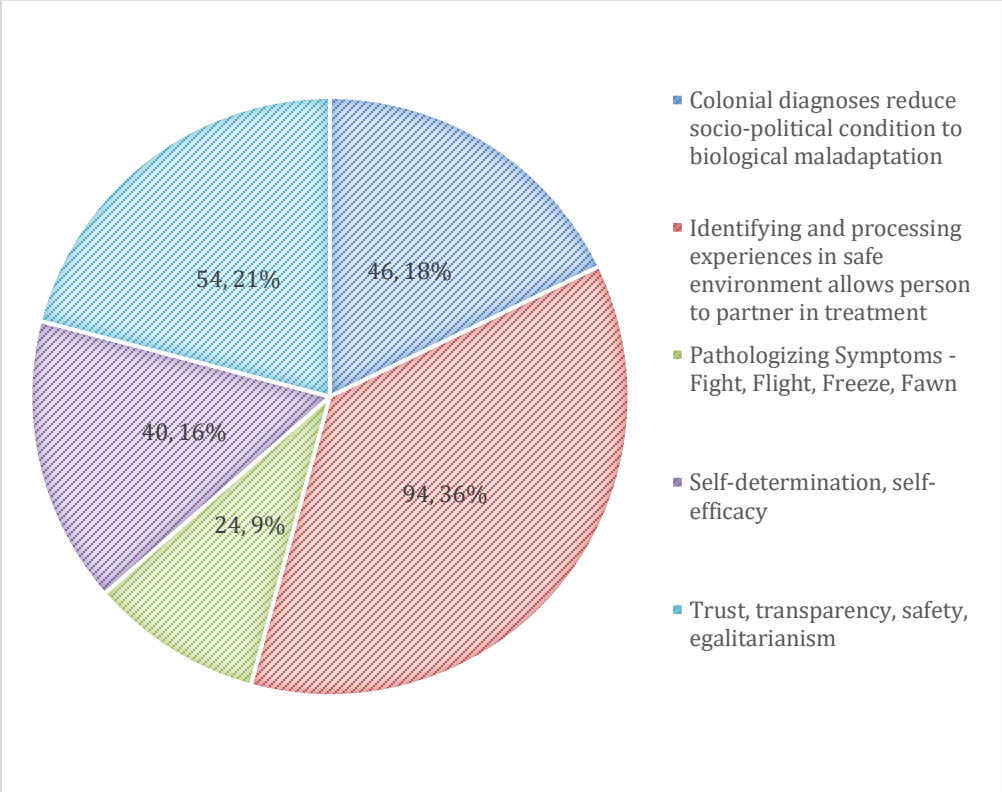
Participant	Interview text excerpt	A priori code
Participant 1	Probably my ability to cope. I've learned a lot through therapy of how to recognize when I am having a trigger, how to cope with the anxiety or the panic attack, how to center myself and kind of bring myself back to normalcy.	Identifying and processing experiences in safe environment allows person to partner in treatment
Participant 2	It kind of took my traumatic event to kind of shake me up a bit and probably that meant what field I am currently going after.	Self-determination, self-efficacy

Participant 3	I'm not sleeping well so I am not giving my full effort any classes the way I have. I can't focus the same way it's been in classes before. and like, this is just like any other illness, like I should making accommodation so that I can still succeed in school, whether that be being flexible with if I can't show up to class because I haven't been able to sleep or if I'm getting notes from someone else.	Pathologizing Symptoms - Fight, Flight, Freeze, Fawn
Participant 4	And then if they're willing to work with you. I'm not saying let people off of deadlines by any stretch of the imagination. But if they're willing to work occasionally with students who are struggling, if they could put something out there that if you do struggle with this stuff, Let me know. That would be helpful,	Trust, transparency, safety, egalitarianism
Participant 6	And there's this stigma of well, everybody wants to get out of the work, and it's like well, you know, people don't have PTSD to get out of their work option.	Colonial diagnoses reduce socio-political condition to biological maladaptation

Once I coded the text excerpts with a priori codes, I used a pivot table to examine the frequency of assigned codes. Figure 1 displays the a priori coding by term and number and percent of codes per a priori deductive code for all text excerpts coded.

Figure 1

A Priori Coding Using Feminist Trauma Theory



Reassembling

In the next phase of data analysis, I began to reassemble the data. I compared the a priori codes with the open codes to determine if any patterns existed. Thus, in the reassembling phase, I looked for commonalities in open coding and a priori coding. I used another pivot table, developed from the information assimilated in the spreadsheet to compare any patterns in the two coding approaches to make further meaning of the participants' responses. During this phase, I also examined the Round two coding and focused on examining the similarities and patterns to discern the categories (Johnson & Christensen, 2020). Table 7 displays the pattern of coding between the a priori codes and

the open descriptive coding. The frequency of the a priori codes are also displayed related to the 258 pieces of coded text excerpts from the participant transcripts.

I used the spreadsheet filters and pivot tables to recontextualize the data. I observed the patterns in the codes and began to interpret the assigned codes by moving to the next stage of data analysis, interpretation. To make meaning of the assigned codes, I looked for patterns in the Coding and considered possible categories for the codes.

Table 8

A Priori Codes to Round 2 Coding

A priori codes to Round 2 coding	Count of interview data text excerpts
Colonial diagnoses reduce socio-political condition to biological maladaptation	46
Barrier/Success	
Community assistance	
Social/Behavioral	
Social/Emotional	
Suggestions/Improvement	
Thrive/Survive mindset	
Identifying and processing experiences in safe environment allows person to partner in treatment	94
Barrier/Success	
Community assistance	
Emotions affecting graduation	
Family support	
Institutional assistance	
Social/Behavioral	
Social/Emotional	
Suggestions/Improvement	
Thrive/Survive mindset	
Pathologizing symptoms—Fight, flight, freeze, fawn	24
Barrier/Success	
Emotions affecting graduation	
Social/Behavioral	
Social/Emotional	
Suggestions/Improvement	
Thrive/Survive mindset	

A priori codes to Round 2 coding	Count of interview data text excerpts
Self-determination, self-efficacy	40
Barrier/Success	
Community assistance	
Family support	
Institutional assistance	
Social/Behavioral	
Social/Emotional	
Suggestions/Improvement	
Thrive/Survive mindset	
Trust, transparency, safety, egalitarianism	54
Barrier/Success	
Family support	
Institutional assistance	
Social/Behavioral	
Suggestions/Improvement	
Thrive/Survive mindset	
Grand total	258

Interpreting

Making Meaning of the Data. Bengtsson (2016) suggested that the codes should be combined and reduced in a manner to maintain the integrity of perceptions shared by participants. I detected emerging categories related to emotions, behaviors, personal circumstances, family and community support, and the need for trauma-informed counselors and mental health professionals. I began to make judgements and interpret the data as I examined the transcripts, spreadsheet with text excerpts, and pivot tables. Table 8 reflects a sampling of the open descriptive codes to the categories that resulted from my analysis.

Table 9

Sample of Open Codes Assigned to Categories

Open code	Category
Emotional Symptom Social/Emotional	Emotions affect graduation
Behavioral Symptom Social/Behavioral	Behaviors affect graduation
Trauma incidents reported were severe overcome with thrive/survive mentality	Thrive/Survive mindset/Personal strength/Resiliency
Academic support Institutional assistance	Disability services/Accommodations/ Individualized academic support from faculty & staff
Personal challenge Barrier/Success	Personal circumstances affect graduation
External support Community Assistance	Private counseling and medication support
External challenge Barrier/Success	Healthcare resources/Trauma-informed staff needed/Communication
Personal challenge Barrier/Success	Disability Services/Accommodations/ Individualized academic support from faculty & staff

Concluding

The pivot tables helped me to identify the predominant categories and patterns. Using the pivot tables and filters, I was able to observe the frequencies of codes, categories and also examine the association between the open and a priori coding. Table 4 reflects open codes and categories derived from interview excerpts. Table 5 reflects the two themes that emerged from the categories related to (a) Although female college students with PTSD perceive personal circumstances affected their academic and social experiences, resiliency, personal strengths, family, and community services contributed to their successful degree completion, and (b) Female college students with PTSD perceive a need for trauma-informed counselors, educators, and mental health professionals who understand PTSD and communicate available services to improve college experiences and promote graduation. These themes were prevalent throughout the interviews.

Table 10

Category Relation to Themes

Category	Theme
Emotions affect graduation Behaviors affect graduation Personal circumstances affect graduation Disability services/Accommodations/Individualized academic support from faculty & staff Thrive/Survive mindset/Personal strength/Resiliency Private counseling and medication support Family support	Although female college students with PTSD perceive personal circumstances affected their academic and social experiences, resiliency, personal strengths, family, and community services contributed to their successful degree completion.
Healthcare resources/Trauma-informed staff needed/Communication Disability services/Accommodations/Individualized academic support from faculty & staff Trauma-informed staff needed Supportive atmosphere Social/Behavioral Participants report that mental health stigma contributed to preventing solutions to mental health needs Outside therapist support	Female college students with PTSD perceive a need for trauma-informed counselors, educators, and mental health professionals who understand PTSD and communicate available services to improve college experiences and promote graduation.

Results

I designed this basic qualitative study to learn about the experiences of female students with PTSD in higher education, to understand their experiences in terms of description and need. The following are the two research questions that guided my study:

RQ1: How do college females with PTSD describe their academic and social experiences in terms of degree completion?

RQ2: What types of assistance do college female students with PTSD feel is needed to improve their college success?

I developed nine interview questions and one follow-up question to illicit responses to answer the research questions. Data collected in the study was grounded in feminist trauma theory, which posits that institutional trauma further pathologizes the experiences of psychological trauma narratives and that reflexivity and co-construction of helps to develop empowerment and self-efficacy (Johnston & MacDougall, 2021; Thompson, 2021).

After analyzing the raw data, two primary themes emerged:

1. Although female college students with PTSD perceive personal circumstances affected their academic and social experiences, resiliency, personal strengths, family, and community services contributed to their successful degree completion.
2. Female college students with PTSD perceive a need for trauma-informed counselors, educators, and mental health professionals who understand PTSD and communicate available services to improve college experiences and promote graduation.

Theme 1: Personal Resiliency

Theme 1 is although female college students with PTSD perceive personal circumstances affected their academic and social experiences, resiliency, personal strengths, family, and community services contributed to their successful degree completion. Female college students with PTSD perceive positive, negative, personal,

and societal factors contributed to their success. All participants described their symptoms as anxiety, depression, distractibility, dissociation, panic, avoidance, procrastination, embarrassment, shame, sleeplessness, nightmares, feeling unsafe around people, difficulty communicating needs, lack of motivation, feeling overwhelmed, and intermittent inability to function or perform in coursework.

Participants described trauma events leading to eventual PTSD diagnoses and difficulty entering classrooms, being in crowds, asking for help, avoiding male teachers and classmates, and sometimes choosing online education to avoid attending classrooms. Participant 2 described a “major barrier is like, getting sleep,” and “after I had PTSD things all around, I had a really hard time sleeping normally and that really interrupted my ability to like being in class and be fully there and fully able to participate the same way. That was a really big problem.” Participant 6 added, “ I couldn't sleep. I think I went for, like, several days without sleep. I couldn't leave my room where I would have a panic attack. And that's kind of when I knew something was wrong.” Participant 8 shared, “I was an insomniac, so I was skipping classes or sleeping through them, couldn't focus.”

Participant 4 described her experience as, “main trauma, occurred when I was an undergrad. I was assaulted on the spring break,” adding that “I didn't really seek out help or anything at that time for them. I turned to a lot more of, like, negative coping mechanisms.” She shared,

> I definitely had a lot of anxiety and depression during that time because I still wasn't fully addressing, like, a lot of the issues that I needed to address. It was super embarrassing. It would definitely be dealing with my depression. I get

> overwhelmed, and then I lose motivation, and I don't want to do anything. It's really hard sometimes to motivate myself enough to do my homework or my assignments or like to put my full self in my classes. And so there have been times where I just I haven't been able to force myself to do my work. And so, then I end up making some excuse for the professor to get an extension or something, because I just couldn't bring myself to do the work. I haven't ever really confided to any of my professors about my trauma in undergrad. But when I'm on my own and freaked out, I'm like so scared because I'm terrified of just hanging out and never finishing it. And I don't want to be the ADD person.

Participants described feeling embarrassed in school, often leading to avoidance. Participant 3 shared, "I'm just gonna have to suffer the consequences, I guess," Participant 4 shared, "Then there's the stigma. The other thing. Like, I don't want them to think that I'm crazy," and Participant 5 shared, "Mostly my experiences in college have been influenced by a panic disorder. A lot that I have that has to do with PTSD. My doctor says it's more sub threshold PTSD and not like full blown. But the panic disorder is what really gives me a whole lot in college because it's just hard to participate fully when you don't know when you're gonna just leave your ability to function. I had so much anxiety about it."

Participant 5 shared, "I mean also, just the overwhelming feeling or the strong feeling of being overwhelmed constantly is really hard. Because with all that's going on in my head, it makes it 10 times harder to just do a normal workload."

Additionally, participants sought to make sense and meaning of their experiences. Most described having dropped out of college at some point in their academic journeys. Participant 5 shared, “My first semester I ended up dropping out because it just got so bad to the point, I didn't wanna go to classes because I had so much anxiety about it. I came back, though, but that really, it made it hard for me,” and Participant 7 shared, “the 15-year break was because of relationship...as the years progressed and the abuse got worse.” Participant 8 shared, “Three colleges and definitely the misunderstanding of people There’s a difference, I think, between being guarded and being conscious. And I think I gave so many bad impressions to people. And I gave such wrong ideas of my personality and who I am.”

Despite pervasive symptoms, participants also spoke in terms of resiliency and seeking connection to others which helped in their successes. Attending classes online, seeking support from approachable personnel, seeking therapy in the community, and reframing trauma experience as a strength were discussed. Participant 2 stated, “ It kind of took my traumatic event to kind of shake me up a bit and probably that meant what field I am currently going after. I think it really kind of started that trajectory. I tend be more open minded with people and their background. I think that trauma was a strength,” and Participant 3 shared, “I can call myself resilient. I feel like everyone told me that I had a lot of tenacity to keep going through adolescence. Good things. I had a very strong motivation to want to make a change in the world and not just, like, accept things as they were,” and Participant 4 shared “I've worked my ass off. I'm a single mom so everything

I went through the last even two years and not quitting and maintaining my GPA," and "I try and be a leader and help others."

Most participants attributed partial resilience to either staying in or returning to school after dropping out to get accurate diagnoses and treatment for their symptoms to family and social supports. Participant 4 shared, "We live with my parents, and so it works out really. My dad's retired, so he takes him to and from school and they help out while I'm doing my homework and at work and stuff like that." Participant 5 shared, "I ended up coming back with a lot of support from family. I never thought that I would come back just because of the stress that it had put me under," and Participant 8 stated, "I had the moral support of my family because I felt comfortable in my own home, and I felt safe."

All participants described stigma about mental health as a barrier to productivity, though they practiced resilient coping skills to overcome stigma. Participant 3 shared,

> I was very social, culturally aware about, like, the artificial things about stigma like for me, everything that I had gone through with sexual abuse already. And I was telling them about that. That's very stigmatized as well. It was insensitive use like that's something that's very similar typing in itself.

Participant 4 shared,

> And so, then I end up making some excuse for the professor to get an extension or something, because I just couldn't bring myself to do the work. I haven't ever really confided to any of my professors about my trauma in undergrad. I wanted to drop out because I just didn't feel good enough to be there.

Participant 6 shared, “And there's this stigma of well, everybody wants to get out of the work, and it's like well, you know, people don't have PTSD to get out of their work option,” and Participant 8 shared, “And so, people who are struggling with mental health and PTSD is just one of those things are like, there's something wrong with them or something.”

Obstacles to success were described in terms of temporary dropout from school were having children to raise, difficulty managing work/life/school balance, returning to school as an older student, finding effective counselors, and being accurately diagnosed, and developing a safe space. Participant 2 described her experience as “...being able to have a safe space to discuss or some sort of open forum, to discuss traumas or to discuss reactions or fall out or, just really, honestly, providing a safe space for a discussion, It's really important.”

The participants of this study expressed difficult internal and environmental conditions as well as neurodivergent responses to classic academic systems. They described themselves in terms of once having been neurotypical and able to process information normally, however post-trauma processing information differently with no visible symptoms to indicate disability (see Biscontini, 2022; Coker, 2022). They attributed their academic difficulties and successes to the responses and resources they were able to access while in their programs. All participants shared experiencing a need for safety and de-stigmatization of trauma-related mental health symptoms.

Theme 2: Trauma-Informed Staff, Understanding and Communication

Theme 2 is female college students with PTSD perceive a need for trauma-informed counselors, educators, and mental health professionals who understand PTSD and communicate available services to improve college experiences and promote graduation. Participants perceived colleges and universities need to provide integrative and holistic trauma-informed care across all disciplines in academia.

Suggestions participants made for assistance needed to improve successful outcomes for female students with PTSD were to have mental health counselors available on campus, online therapists for students, therapists trained in PTSD specific therapies such as Eye-Movement and Desensitization Reprocessing (EMDR), Acceptance and Commitment Therapy (ACT), Cognitive Processing Therapy (CPT), Mindfulness and Yoga centers, transparent and available mental health resources, and trauma-trained staff and faculty.

Participant 1 shared,

> Therapists who are trained in EMDR. So I think that training is excellent. I think they should do more research into it and have more therapists trained to perform it. A community counselor. So, I think if that were available to campus student or even online students where they had resources that they could tell them for their area. Where to locate these resources.

Participant 2 shared, “being able to have a safe space to discuss or some sort of open forum, to discuss traumas or to discuss reactions or fall out or, just really, honestly, providing a safe space for a discussion, It's really important.” Participant 3 shared, “having support groups that

are focusing on other types of mental health, maybe yoga, other, positive atmosphere that you can start feeling in groups together I think would also be very beneficial. It's harder now because of the focus."

Participant 3 also shared,

> And so, it took me until the middle of my senior year to realize that I had PTSD. And then I even asked my physician about it because I went to a different counselor and she was the one who told me, and we started talking about it. And we went to like, all of the things about my how my trauma impacted me and everything, but I still didn't even know that it was ADA like the thing that I should have been getting accommodation for. I didn't know how to vocalize like cause, you know, PTSD is one of those things that is ADA. Like I thought I always I always apologize to my professors. I always took full responsibility for the consequences of it. Not realizing. And then that gave my professors the viewpoint that oh, we shouldn't be doing anything extra for the student anyway. I went through to my counselors at my school counseling for a while, also talking about these, but none of them are really trauma informed so they didn't know how to help me then. I didn't really get the best sort of care that I would need to be able to understand, how to navigate college world.

Participant 3 described her experience in needing trauma-informed staff in terms of the faculty not recognizing that a disability was present and that it qualified under the American with Disabilities Act (ADA):

> So, my professor, I remember trying to navigate it with, a director of the honors program and, like, how do I get back on this track? And he was just very much like, you know, I understand you're going through a hard time. Like I was expecting you to be able to pull it all off. And then I also had a thing happened with the professor that maybe just not feel comfortable in classes anymore. And so, that made it so like I wasn't able to fully navigate. My teacher didn't understand that. I told people everything about I told my general physician at the school, student health services. I told the confidential reporter I told people in the counseling, especially at the school. And then it was a grad school clinic is what I ended up moving to, which had the better person. Who's better able to say, Oh, have you ever had anyone ever talked to you about having PTSD? And then we went through all of the things to be able to be diagnosed and like realized that this is something I was dealing with. But no one ever told me that that is something that qualifies under at a like no one ever told me that mental health things means that you should be able to participate and have accommodations so that you can still succeed.

Participant 3 described her experience further as

> I'm gonna do my assignments and here is when I'm gonna do everything. So, I make sure I'm on track, but I never know when I'm gonna have PTSD. How long it's gonna throw me off the rails to take me to get back to normalcy and be able to get back in. So, it's not like something I can plan for right and be like Okay, I might. Because of this, I should ask for an extension already or like I like it makes

> it makes a lot of stuff that you like. Oh, you're just making excuses over and over again. But that's not what you're doing. You're trying your best still function and show up every day and do the best you can, and PTSD isn't just so simple like that.

She once again emphasized the stigma surrounding PTSD:

> It's not something you wear on your shoulder and let everybody see, because it is something very stigmatized. It's something very intimate and something personal and like you're more vulnerable if you wear those on your sleeve, so I don't know. It's just like being judged without understanding the intricacies of how it impacts you. I feel like if people are more trauma informed and can break past some of those inside biases, if they have it and realizing it at the same level of any other type of medical issues.

Participant 3 spoke extensively about needed resources. She discussed the financial impacts of missed opportunities, prolonged education and medical treatments, difficulty knowing about or having accesses to helpful trauma-informed resources, “healing group that someone can have part of a community to start not feeling like so much like an outcast,” food and rent supports.

Other participants recommended trauma-informed extra-curricular and service clubs and organizations. Participant 4 shared,

> I’m a therapist and legit actual PTSD is a very difficult diagnosis to obtain. But there's a spectrum of trauma disorders that may not be in the DSM. So, like, that's kind of the label that everybody gets like slapped with right and a lot of people

> associated with, like, combat or something. Everybody runs around saying they have PTSD when they don't have anything close to PTSD. You know, like they don't have a clue what that even means or entails, because if they did, they wouldn't be functioning where they're functioning.

She added that, “I think that one having professors more educated on like, kind of the spectrum of trauma and what it looks like and, like various things that can cause trauma are important.”

Other participants discussed the difficulties in getting accommodations they needed, of having interfering physical symptoms accompanying PTSD symptoms. Participant 5 shared that after discovering her diagnosis was PTSD she chose to major in social work where “They know that it’s there and they're usually very supportive and the department I'm in is a very understanding atmosphere. So, it's been a lot easier than probably if I had gone into something else, because I know people who are in different departments who have similar issues.” She also shared that her campus “have the disability services. It's just difficult to access. And if you don't know about it, then you might not access it.” She discussed her difficulties in getting accommodations and of having to educate disability services about her diagnoses after going through an appeal process after failing the previous semester.

Participant 5 shared,

> I mean more education, really. Because a lot of people I think are not educated, even on what it is. And a lot of people go to college and experience this. Just experience extreme struggle, and they don't know what's going on. Also, I feel

like the services that are offered should be more out there to the public. I feel like, in freshman Orientation.

Participant 6 shared, “having trauma training across the board for all the teachers would be would definitely be amazing.” She also shared that more therapists are needed “because there is a huge wait list for students to be able to get in. Like sometimes students can't get into several semesters, and that's just detrimental to their mental health,” and, “honestly, I didn't realize until a year and a half into being at the school that they had a counseling center. So just awareness for that. so, it would have been very helpful to know about it.”

Participant 7 suggested that “more webinars or information about dealing with or tying it in,” would be helpful, and Participant 9 suggested that Christian universities also provide trauma services, stating that her friends in public colleges had more support for mental health issues in general.

The participants of this study conveyed a need for trauma-informed staff, faculty, and services in higher education. They shared that their quality of experience, time spent earning their degrees, and mental health were negatively impacted when these factors were not made available to them. Moreover, they all shared a sense of disconnection from neurotypical influences and each shared experience with feeling reconnected and able to proceed towards degree completion.

Evidence of Trustworthiness

Credibility

Credibility is ensuring that data is correctly collected, analyzed, and interpreted in a way that accurately represents the study and its' findings (Yin, 2018). To maintain credibility I transcribed, categorized, analyzed, and coded with the intention of remaining with the study's goals. Interview time allotted per participant was 30-60 minutes. However, interviews ranged between 13 minutes to 46 minutes and an average interview length of 27 minutes. Participants spoke rapidly and covered a lot of material in a short period of time, which is common with PTSD (see Fernández-Lansac & Crespo, 2015). Saturation was determined when responses had answered the research questions and interviews ceased producing added information. Reaching saturation is important to credibility. I obtained a repetition of repeated information from the recruited participants and therefore credibility was further supported.

I used the interview protocol to ask all participants identical questions that were aligned to the research questions to maintain continuity. Another way I increased the credibility of the study was to retain participant confidentiality by coding each Participant with a numeric pseudonym such as P1, P2, etc. and I did not collect demographics such as names of schools attended, addresses, or last names. During the interviews, when the participants made statements such as, "I don't think this has happened to anyone else, so it could identify me," or "I don't know anyone else who's been through what I've been through and gotten this far along in her education," I assured them that I would not be divulging the nature of the trauma incidents they described as a measure of identity

protection. Providing participants with confidentiality supported the rapport and integrity of the participants' responses as they understood their responses were being held in confidence. Additionally, the recruitment process included the Study Invitation with IRB approval number, assurance that no names would be collected or stored, followed by the letter of consent, which helped to establish trust with each participant.

To increase credibility, I triangulated data by using different forms of coding. Triangulation aims to increase credibility by comparing data from various sources. According to Jick (1979), the effectiveness of triangulation is based on the idea that each variable's weakness will be offset by another's strength. In this study, I used triangulation to encompass a combination of descriptive processes using a spreadsheet to examine the frequency of the assigned a priori and open codes after each round of coding. The a priori coding process involved the development of a set of codes based on the conceptual framework for this study. I immersed myself in the data collection from participants to identify which parts of the data fit the conceptual framework, and to see if new data emerged. The open-coding process involved reading and re-reading the data collected during individual interviews to identify codes. Using this deductive and inductive coding process, I engaged in two different coding approaches to analyze a single source of data collected from participants in this study. According to Jick (1979), triangulation serves to provide a research strategy of convergent validation using various methods. These approaches supported convergent validation of the phenomenon being studied (see Flick, et al., 2012). I compared the coding that resulted from the different approaches and observed alignment with a priori and open codes that validated feminist trauma theory. I

also used a peer-review process by asking a colleague to hand-code some of the transcripts and I compared and assessed for similarities and differences in codes (Flick, et al., 2012; Jick, 1979). Researchers note that using a peer review and debriefing process helps to produce reproducible research by providing transparency, vulnerability, and insight (Amin, et al., 2020; Laine, et al., 2007). I used a research journal to note thoughts as I interviewed participants and as I coded the interviews. Researcher's journals are used for providing a data set on the act of research in refining the understanding of study participants (Janesick, 2011). I used member-checking to allow participants to assess accuracy. Member checking is when the researcher reaches back to participants to invite them to check for accuracy regarding the content of their interview data (see Janesick, 2011). I sent each participant a copy summary of findings, inviting them to assess for accuracy. I received confirmation via e-mail from two participants that the information was accurate.

Transferability

Transferability is the degree to which findings of the study can be universally applied to other studies (Bengtsson, 2016). To determine transferability, I coded with the intent of responding to the research questions as well as being aware of any themes which may have offered insight for future research. My explanation of the data aligned to the conceptual framework, feminist trauma theory (see Wilkin & Hillock, 2014), and allowed for participants to tell their experiences through a reflective and empowering, validating process. The findings of this study can be applied to other studies to broaden and deepen the information found in this study, as well as to provide opportunity to further fill gaps

in literature about trauma informed practices in higher education. The length of the interviews is not thought to play a detrimental role in the transferability of the findings due to reaching saturation.

Dependability

Dependability refers to having a reliable research design, accurate explanation of the data, and integrity of researcher data analysis. To establish dependability, I followed IRB dissertation protocols to maintain integrity of the approved process by maintaining a transparent audit trail (see Carcary, 2020). All documents used for the interview, management, and analysis process were saved on a password protected personal laptop. I used reflective journaling throughout the research process to bracket my experiences, feelings, and thinking about the data, adjusting codes, labeling, and relabeling data as necessary (see Janesick, 2011). To verify dependability, I ensured that the data answered the research questions and aligned with the conceptual framework, feminist trauma theory (Wilkin & Hillock, 2014). Participants engaged in member checking, by reviewing a draft of the study findings and were invited to share their insights or feedback on my interpretation of the information. This process also provided participants the opportunity to confirm or question the findings. Finally, I interviewed until saturation was reached (see Fusch & Ness, 2015). Furthermore, data analysis aligned with the conceptual framework using a priori coding and open coding that revealed congruent codes, categories and themes thereby confirming the results.

Confirmability

Confirmability is to share data so that it presents as neutral, objective, and can be confirmed by others (see Amin et al., 2020). To assure confirmability I ensured that the coding process linked all findings to the study's research questions. Reflexivity included researcher note-taking, evaluating and re-evaluating participant responses against the research questions and consulting with mentors, committee members, and advisors throughout the data analysis process (see Janesick, 2011).

Intra-coder reliability refers to the means of checks and balances, or measurement of stability and lack of coder bias in data analysis (Rodríguez-Morejón et al., 2018). I asked a professional who is unfamiliar with the study to code an interview to compare with my coding responses to ensure that the coding was sound (see Rodríguez-Morejón et al., 2018).

Discrepant Data

While analyzing the interviews I looked for similarities and differences in the data. Other than all interviews lacking depth and richness due to the brief style of data collection, all participant responses were similar in content. There were no remarkable differences, although some participants offered less information than others. There were no rival responses from the data that conflicted with the themes.

Summary

In this chapter I described the approaches I used for data collection, data analysis, and the specific coding strategies used to make meaning of the data. Nine participants agreed to engage in semistructured interviews. I used 2 Rounds of descriptive coding and

1 Round of a priori coding to explore the relationship of the information obtained in the interviews to the research questions. Using feminist trauma theory as the conceptual framework for the study, I described two meaningful themes that emerged from the data analysis process.

Most participants shared helpful experiences from Resident Assistants (RA's), professors, camp counselors, and enrollment counselors who they said contributed to their success in college. In addition to the option to attend classes online, some stated that taking a break from school while undesirable, allowed them to get properly diagnosed and learn healthy coping skills to manage interfering symptoms upon returning to school. Upon returning to college and receiving adequate help to manage PTSD, students reported that writing centers, ADA services, correct medications, PTSD-targeted therapies, and trauma-aware university employees were helpful.

While all participants expressed gratitude for one or more aspects of their education, most often having graduated in good standing, all expressed having had to drop out or take additional time to graduate because of the lack of trauma awareness, knowledge, and training in colleges and universities. The prevailing suggestions by participants for needed support in colleges and universities were trauma-informed staff and faculties, more counseling and trauma-informed services, and transparent availability of resources (see Champine et al., 2022). Consistent with emerging literature is the need for community-based, trauma-informed staff and professionals in an increasingly demanding environment.

In the following chapter I will interpret the findings, describe limitations, provide recommendations and implications of the study.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative study was to explore the experiences, beliefs, perceptions, attitudes, and needs of female college students with PTSD and what they identified would guide them towards successful graduation. A basic qualitative study was appropriate because the focus of the study was understanding the experiences of female students with PTSD in higher education using a basic interpretive approach (Merriam & Tisdell, 2016). Additionally, a gap found was that there was no literature focused on programs intended specifically to address the needs of female college students struggling to cope with symptoms of PTSD.

In this study, I hoped for emerging themes that might provide a framework for further study to inform colleges and universities about the needs of women with PTSD in higher education. The research questions were aligned with the conceptual framework that I chose, which was feminist trauma theory. According to Pemberton and Loeb (2020), feminist trauma theory utilizes tenets of trauma-informed care, which include safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical, and gender issues. Within this context, interviews of female students with PTSD promote empowerment by collaborating and assisting in telling their experiences and promoting opportunity for positive change (Pemberton & Loeb, 2020).

Findings from this study were consistent with literature. The foundation of feminist trauma theory in therapy is that it relies on self-determination and self-efficacy while establishing an environment of trust, safety, and egalitarianism (Pemberton &

Loeb, 2020). In areas participants identified as successful, these elements were present, and in areas participants described as needing support, they were lacking. For example, participants described somatic symptoms consistent with females experiencing PTSD. All participants reported feelings of heightened anxiety, difficult time in crowds, avoidance of perceived threats, and of experiencing panic attacks. Additionally, consistent with literature findings, all participants developed PTSD after experiencing domestic and gender-specific abuses (see Burstow, 2003; Evans et al. 2005; Thompson, 2021). All participants reported having gone undiagnosed and/or misdiagnosed for a period of time before receiving the final diagnosis of PTSD, and all reported having significantly improved academic, personal, and professional experiences after receiving PTSD-related interventions to promote social inclusion, relationship-building, and personal empowerment. Consistent with literature, participants reframed their traumas as strengths and used words and phrases such as "I think that trauma was a strength," "I was always an overachiever type person," "It's just like any other illness" and is therefore worthy of accommodations "so that I can still succeed in school," and relying on past successes to fuel future hopes. One participant stated, "I can call myself resilient. I feel like everyone told me that I had a lot of tenacity to keep going," and another stated, "I had a very strong motivation to want to make a change in the world and not just like accept things as they were" (see Burstow, 2003). Finally, all participants reported that having a safe space to feel heard and supported was instrumental in promoting their positive academic experiences, which is consistent with feminist trauma theory.

Participants explained their social lives as having changed remarkably after their trauma events leading to PTSD, turning more towards academics, professional success, and becoming agents of social change. One participant reported that she became more involved in succeeding academically and publishing a book, and another reported feeling fulfilled working as a barista, mentoring, and supporting young people. Academically, all but one student either dropped out for a while to understand and learn to cope with their trauma or took a short leave to do so. Upon returning to college, all participants learned to advocate for themselves and to be creative and proactive in accessing any resources to help them towards completion. All participants discussed the impact that mental health stigma and lack of trauma-informed staff had on their experiences.

Interpretation of the Findings

I began this basic qualitative study to explore the experiences and needs of female students with PTSD in higher education. In the literature review, I included an explanation about trauma theory in general, and more specifically, feminist trauma theory, which states that trauma is resolved by empowering participants through the telling of their own stories in safe, trusting environments, and by cofacilitating the healing process with them (see Brown, 2006; see Pemberton & Loeb, 2020). Female students with PTSD experienced challenges understanding and managing their interfering symptoms of PTSD within the traditional academic counseling model.

PTSD is a condition that is not easily diagnosed in women and in many cases is misdiagnosed as borderline personality disorder, major depressive disorder, generalized anxiety disorder, and other disorders with symptoms similar yet not completely inclusive

of those consistent with PTSD (see Riddle, 2018). Traditional college counseling center staff are not usually trained in trauma therapies and fail to meet the needs of students with PTSD, particularly female students who have experienced traumas and enter colleges and universities and experience symptoms of trauma that they do not understand and that are undiagnosed. In this study, all students explained their process and academic experiences in learning to manage and succeed despite learning that their interfering symptoms created barriers to the traditional model of universities and colleges in the United States. All but two students stated that they left college before returning in order to obtain an accurate diagnosis for their symptoms and to learn healthy ways to manage their symptoms while earning their degrees. All participants chose social and human sciences as majors after learning of their PTSD.

In Theme 1, I found that having a sense of personal resiliency was key in participant-perceived experience of success. All participants reported a sense of resiliency, determination, "stubbornness," or a higher sense of purpose in reaching their academic goals. While family support was mentioned and was consistent with literature about female PTSD, it was the desire to lift away from being a burden to family and to attain a sense of autonomy and accomplishment as women that maintained importance. All participants reported that even when college resources were unavailable, they found the diagnoses and interventions they needed to manage returning to their academic programs, and all used humor as a coping skill (see Thomas et al., 2022).

Despite their reported difficulties such as inability to sleep, avoidance issues, panic attacks, intrusive thoughts, nightmares, at times hallucinations, and social anxiety,

all participants reported that it was their tenacity and focus on successful graduation to which they attributed their success. Interestingly, though they discussed their difficulties extensively, elaborating on their resourcefulness and creativity was most prominent in their narratives, which supporting literature confirms (see Karatekin & Ahluwalia, 2020).

In reviewing the data related to Theme 2, I found that there is a need for trauma-informed counselors, educators, and mental health providers who are trained to understand trauma and PTSD in colleges, as well as a need for those who are able to communicate to students about available services and programs to improve student experiences and graduation (see Conley et al., 2017). Participants explained in detail the hardships and difficulties they experienced as they navigated uncharted territory on their own and with limited help and resources. Although they expressed frustrations about mental health stigma and ignorance about mental health in academia, they were eager to participate and to share. All of them reported that they felt that the lack of PTSD knowledge and services was a result of training and policy deficiency rather than a lack of caring. This is consistent with the lack of literature found to support training, programs, and policies for trauma and PTSD in colleges.

Descriptions of How Posttraumatic Stress Disorder Affects Successful Outcomes

Theme 1 was that although female college students with PTSD perceived that personal circumstances affected their academic and social experiences, resiliency, personal strengths, family, and community services contributed to their successful degree completion. Traditionally, institutions of higher education were developed to meet the needs of high school students moving towards careers in their communities requiring

education beyond the “blue collar” industries. Historically, academia was developed for the advancement of White male economies and has incrementally advanced to include a broader population that includes female, racially diverse, and LGBTQ+ individuals and that thus represents contemporary society (O’Donoghue & Harford, 2022). While research is emerging about the impact that COVID-19 had on trauma responses, as early as the year prior to COVID in 2018, females were twice as likely than males to have PTSD and were less likely to seek help for trauma symptoms due to the shame and stigma attached to acknowledging vulnerability and gender stereotypes (APNA, 2018; Treiman, 2018).

All of the participants in my study identified their personal strengths as resilience, determination, detail orientation, perseverance, conscious focus on the positive despite internal or external challenges, passion to succeed, strong research and writing skills, reliance on helpful staff and professors to bridge difficult circumstances, self-advocacy, and gratitude. They identified external strengths in terms of having good fortune in meeting with supportive and helpful staff, faculty, friends, family, and community mental health services. Seven of the nine participants stated that they dropped out of higher education for a period of time to obtain accurate diagnoses and to learn skills to manage interfering symptoms. All reported frustration about the impact that having PTSD had on their finances, length of time to degree completion, and quality of life. Participants’ negative narratives were about symptoms of avoidance, overwhelm, anxiety, panic, depression, feeling unsafe, worthlessness, intrusive memories, COVID disruptions, work/life balance, and lack of university resources to recognize or to meet their needs.

Types of Assistance Needed to Improve Successful Outcomes

Theme 2 is that female college students with PTSD perceive a need for trauma-informed counselors, educators, and mental health professionals who understand PTSD and communicate available services to improve college experiences and promote graduation. In 2017, a trauma-informed and sensitive college model was developed to address homelessness and housing insecurity in colleges and universities due to outdated and insufficient state and federal financial and structural policies in higher education that no longer met the growing needs of contemporary students (Hallett & Freas, 2018). The study reflected an understanding of the historical colonial perspective that trauma and social injustice are met with a charitable perspective, and one that serves no one proficiently or sufficiently in today's struggling socioeconomic climate (Hallet & Freas, 2018). Congruent with participant reporting in this study, those working in institutions of higher education were resistant to embracing a holistic approach to address homelessness and mental health issues because of the long-held notion that education and social services are separate and mutually exclusive entities.

Participants in my study identified types of assistance that would have been or would be helpful to them in terms of feeling validated and empowered to succeed in their programs as additional financial resources; housing resources; comprehensive trauma-informed counseling centers; therapists educated in trauma-informed therapies; transparent resource guidance; online counseling resources; trauma-informed curriculum with embedded options for those struggling with PTSD; organized safe space for individual and group discussion; trauma-trained and informed staff, administration, and

faculty; broader inclusion of trauma understanding and implementation in disability services; fewer barriers between disability services and administration; more policy-driven accommodations for PTSD and destigmatization; institutional employee advocates for PTSD; and trauma-informed interdisciplinary medical and mental health centers on campus.

Findings Related to the Conceptual Framework

The conceptual framework for this study was feminist trauma theory, which developed over time as a combination of feminist theory and formerly untraditional trauma interventions suited towards populations outside the normative definitions of the DSM-III-R, DSM-IV, and the most current edition, DSM-5 (see Burstow, 2003). The theory relies on the principles of self-determination, self-empowerment, trust building between practitioner and participant, empathy, patience, egalitarianism, and safe-keeping in the therapeutic process as the iterative and reciprocal relationship unfolds between professionals and populations being served. It also relies on the participants making meaning of their experiences, rather than only taking into consideration the traditional psychiatric medical model's authority over diagnostic criteria and definitions, which do not encompass all populations.

In this study, findings consistent with the conceptual framework were that despite all participants entering college not knowing that they had PTSD, all not having the resources readily available to gain access to the assistance they eventually all found, and most having taken a break from college to re-evaluate their conditions, all were resilient women who advocated for their needs in resourceful ways, and all shared unique

circumstances and experiences, leading them to use their personal strengths to identify and communicate their needs to those who would listen and help them to reach their goals.

Each participant in the study verbalized that at one or more times in their academic journeys, they confronted the option of failure and chose instead to rise to their dreams and overcome their structural obstacles. Participants discussed their experiences with not being heard, being misdiagnosed, and feeling shamed for what happened to them versus being heard and understood by people who were trained or willing to listen and to help them to achieve their goals that needed to be achieved with a college education. All participants chose to pursue social, human, and entrepreneurial services, expressing their empathy and desire for all people to be deserving of equal rights and opportunities despite limitations imposed on them by societal oversight of unintended consequences of violating acts and discrimination, uncertainty, and social injustices.

Additionally, findings consistent with feminist trauma theory were that the women in this study sought help where they could safely explain their situations, symptoms, and context and engage in conversation about ways to reduce adverse effects of trauma while receiving personalized assistance to increase resilient behaviors. They expressed that in doing so, they realized a need for trauma-informed counselors, educators, and mental health professionals who understood PTSD and could communicate available resources to students with the intention of creating inclusivity and increasing graduation rates in this population (see Champine et al., 2022; Kline & Palm Reed, 2021). Remarkably, all participants expressed their desire consistent with feminist

trauma theory values of collaboration, egalitarianism, and phenomenology that their stories be recorded in such a way as to begin a conversation in academia to include PTSD awareness and trauma-informed practice in higher education with the intention of encouraging all students experiencing PTSD symptoms to succeed in college (see Evans et al., 2005; Kline & Palm Reed, 2021).

Limitations of the Study

This study was based on basic qualitative methodology, which was limited in gathering depth and breadth of information. It had the following limitations: potential for researcher bias, reliance on participant full disclosure without supporting documentation, and small sampling of only nine participants. To limit researcher bias, I maintained a personal journal throughout the study and bracketed my own experience with PTSD (Fischer, 2009). I bracketed my own experiences with PTSD as a means to remain focused on what the participants were reporting without allowing my own biases, experiences, and perceptions to interfere with the data. Using a reflexive and iterative process, I identified and examined with self-awareness by journaling in my own therapeutic process to ensure that my own narrative did not influence participant disclosures. I compared my personal perceptions and experiences with PTSD to those of the participant experience with intention to avoid countertransference, while sharing my personal thoughts, feelings, and experiences in my own individual therapy process. In this way, I was able to reflexively separate myself from the emerging data (see Ahern, 1999).

My role as a researcher was to accurately collect, document, and interpret the data obtained from the interviews. As an LCSW my role is to accurately diagnose, collect, and document data as a therapist and to provide appropriate evidence-based interventions for those seeking mental health services (see NASW, 2023; Sur et al., 2023). While these roles are similar, I confronted the limitations in the research by keeping a separate journal of my thoughts about findings as a researcher, rather than as a therapist. To compensate for full-disclosure without supporting documentation I used member checking before the completion of the study to ensure that I captured participant stories accurately, by sending each participant the findings of the study and offering them the opportunity to make changes or to clarify if necessary (see Creswell, 2013; Ravitch & Carl, 2019). Two participants responded and indicated no changes were needed to the draft findings. Both participants thanked me for sending them the draft findings.

Recommendations

This study contributed to a growing body of research concerning comprehensive trauma-informed practices in higher education. When I began the study there was little to no literature about female students with PTSD and their experiences in higher education. My goal was to fill that gap and to begin to inquire about what their experiences, perceptions, and needs were. Based on the findings from this research, I recommend further research to explore a larger population of students with PTSD and their experiences, perceptions, and needs. I also recommend a mixed-methods or quantitative study which include counseling center programs and policies implemented since 2017 to ascertain the need for comprehensive trauma-informed policy and implementation since

global crises such as COVID-19, racial, and gender issues have changed the landscape of trauma and college participation.

A quantitative or mixed-methods study would allow for data to be collected through supporting documentation, focus groups, surveys, and interviews, and comparison studies between student populations and university supportive services. Furthermore, the more inclusive data collection such as online surveys and focus groups might unite students and college staff in ways that could eliminate or influence the sense of isolation and sense of aloneness that participants expressed. Additionally, as this research study only focused on the participant population of female college students with PTSD, more studies encompassing complex trauma, racial trauma, gender trauma, and other types of traumas would inform stakeholders regarding policy development as well.

Implications

The purpose of this qualitative study was to explore the experiences, beliefs, perceptions, attitudes, and needs of female college students with PTSD and what they identify will guide them towards successful graduation. This study helps to address the gap in research about the needs of students with PTSD in higher education. Although the sampling was small, participants shared experiences, perceptions, and needs that were starkly similar.

Positive Social Change

Implications for positive social change at the individual level would be a higher rate of retention, satisfaction, self-efficacy, improved mental health, and contribution to community after graduation. At the family level positive social change may include

future generations of college enrollment as the burden of mental health is lifted from the sole responsibility of self and family (see Mercadal, 2021). Additionally, one participant mentioned that she and her family would have appreciated mental health resources being addressed at the initial Freshman Orientation that the family attends. All participants expressed gratitude for the assistance they were able to receive for their PTSD. However, no participant extolled praise for the organizational deficits in policy needed to address contemporary mental health issues which include PTSD. Therefore, recommendations for practice is to continue to research and implement evidence-based policy and programs to address the mental health needs of college students with PTSD.

Theoretical Implications

Themes revealed that female students with PTSD experience at a minimum the standard DSM-V criteria and symptoms of PTSD yet do not experience remarkable, if any accommodations for the disability. Additionally, because there were no academic trauma-informed resources or cultural climate for students with PTSD, student symptoms persisted untreated and undiagnosed until one or more academic failures brought about accurate diagnosis and treatment before academic success was possible (see Champine et al., 2022).

Historically, versions of the DSM are limited in demographic focus, and have not satisfied the definitions for mental health diagnosis concerning psychological distress caused by oppression (see Evans et al., 2005). Feminist theory continues to inform trauma theory as it evolves with critical race theory, transgender issues, COVID issues, and other topics of vulnerability while removing pathology from traumatized expressions,

as feminist trauma theory views PTSD as a compilation of symptomatic reactions to physical, spiritual, social, mental wounds (see Evans et al., 2005). One of the more difficult aspects of feminist trauma theory has been the challenge of balancing inclusivity with objectivity, or more simply, remaining open and flexible to the unknown while also creating a unified approach that provides evidence-based science and interventions to remain theoretically sound (see Evans et al., 2005). One example is that when feminist theory was being developed by white women in the 1960s, black women's traumatic experiences were negated thus negating feminist trauma theory's basic values and culminating in the "womanist," movement developed by African American women (see Evans et al., 2005; Richmond et al., 2017).

In summary, feminist trauma theory has come a long way since its inception forty or more years ago and is a theory that will continue to evolve if it remains true to the core values of egalitarianism, social justice, collaboration, and phenomenology (see Evans et al., 2005). It is an altruistic theory that follows struggle, seeks to understand, and raise consciousness outside of the mainstream society's comfort zone with privilege, complacency, and oppression. For feminist trauma theory to continue to progress, collaborative evaluation of marginalized populations and study about how social context influences mental health and interventions is crucial (Richmond et al., 2017)

Recommendations for Research and Practice

Implications for future research and implementation are for our country's education policy to address the needs of all students struggling to make a positive difference in their own lives and in the lives of who they affect in their academic

disciplines. Before the COVID-19 pandemic there were warning signs of trauma distress, however since the pandemic it has become quite clear that colleges and universities need to adopt trauma-informed policies and practices to encourage the promotion of successful student outcomes and graduation (see Liang et al., 2020).

In recent years the U.S. has experienced unprecedented violence and illness resulting in traumatic responses to internal, external, environmental, political, and social wounds. Feminist researchers have argued against PTSD diagnoses which further stigmatize and marginalize groups who are already struggling with exploitive policies and ideologies (see Richmond et al., 2017). However, globally researchers and trauma specialists are expanding the knowledge and understanding of trauma to better meet the needs of all those asking covertly and overtly for entry to traditionally privileged systems of preventative and restorative trauma interventions. It is important to factor in strengths-based, evidence-based, science-based, and practical considerations about PTSD diagnoses and interventions that are influenced by pharmaceutical, insurance, and medical intervention that the diagnosis provides (Richmond et al., 2017).

Finally, as researchers continue to discover more about trauma and ways to address individual and collective situations, colleges and universities are fertile grounds for pilot programs, innovative programs, policies, and interventions to address the effects of trauma on individuals, groups, and communities, and to develop ways to heal and promote positive social change.

Conclusion

The implications for positive social change in higher education are powerful if academia were to harness the groundbreaking body of trauma research developed by leaders in the medical, mental health and educational fields and implement resources for student healing and excellence in higher education. For example, it is well known that trauma subject matter experts Dr. Bruce Perry (Perry 2001, 2014; Perry & Ludy-Dobson, 2010; Perry & Winfrey, 2021), Dr. Gabor Mate (Mate, 2022), Dr. Bessel Van der Kolk (Van der Kolk, 2022), Francine Shapiro (Shapiro, 2020), Peter Levine (Levine, 2022), and many others in the field have researched the human brain, neurobiology, and the impact that trauma has on all aspects of human functioning and that all espouse that trauma is healed through connection, relationships, empowering experiences in safe environments, understanding oppression and authentic communication. While my participant population was small, each participant was eager to participate and even more eager to grasp hope for future students to have resources available to them that they had not been afforded, and each was eager to share their story of trauma, resilience, pain, and recovery.

In a recent study about college enrollment and retention the authors found that both enrollment and retention were beginning to decline before COVID -19 and have continued to decline since, and that retention and enrollment rates have increased in already privileged populations and where financial incentives have increased for less affluent public high schools (Howell et al., 2022). While enrollment and retention rates varied greatly across regions, what was remarkable were the differences in 4-year and 2-

year college enrollments after the pandemic, and the lowered retention rates in all racial/ethnic groups after 2020 (Howell et al., 2022). It is widely known that the pandemic is one of our global trauma milestones, furthering the implication for trauma-informed policy to inform academic practices for all students in higher education.

Feminist trauma theory is trauma theory that includes the female perspective of painful and life-damaging experience. Trauma theory posits that trauma is a neuro-biological response to life threatening, unsafe situations. Feminist trauma theory posits that what is considered "normal" in male, patriarchal society is damaging to the biological and social roles of people. Academia in the United States is white, male, colonial and patriarchal and has not afforded women or diverse populations to breathe freely to voice their experience in a hetero-focused society.

The reason I selected feminist trauma theory as the conceptual framework for this study was to challenge the institution of academic purpose in the United States of America in which White, colonial, male reality is considered the benchmark of reality and sanity, and which has never served the mental health realities of most of its population experiences in contemporary education (Curtis, 2022). The nine participants who came forward to participate during COVID-19 expressed relief and gratitude that they might have a voice in research and an opportunity to contribute to helping others with PTSD. While none of them spoke poorly of their colleges, all of them expressed their frustrations and painful experiences in navigating an organizational culture that does not recognize PTSD in a non-military context, and relief in finding solutions towards graduation within their families and community resources.

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