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The Process of Enduring Prolonged Undiagnosed PTSD and the Impact of Treatment Expressed by Women

Kelli Elaine Hudgins
Walden University

Walden University

College of Social and Behavioral Health

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Kelli Elaine Hudgins

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Review Committee
Dr. Jade Letourneau, Committee Chairperson, Counselor Education and Supervision Faculty
Dr. Tiffany Crayton, Committee Member, Counselor Education and Supervision Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

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Abstract

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by

Kelli Elaine Hudgins

MA, Lamar University, 2021

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Prolonged undiagnosed posttraumatic stress disorder (PTSD) has been examined from various perspectives and represents a significant medical concern across diverse populations. Research on PTSD often targets specific groups, such as postpartum women or military veterans. This narrow focus in much of the literature tends to obscure the broader impact of prolonged undiagnosed PTSD on the general population, thereby overlooking the critical need to highlight systemic shortcomings that hinder effective interventions and reform. Furthermore, personal narratives detailing the challenges individuals face when seeking help or treatment – factors that contribute to delays in care – and the subsequent effects on their well-being are seldom documented. Consequently, this constructivist grounded theory study investigated how women who have had prolonged undiagnosed PTSD experience the treatment process and how finally receiving treatment influenced their lives. Intensive semistructured interviews were employed to collect in-depth, narrative-rich data from women trauma survivors aged 40-60. Analysis through open, focused, and axial coding indicated that the process of PTSD diagnosis and treatment can be more traumatizing than the initial event. Insightful categories emerged, such as lack of language, stolen voices, isolating changing for their children, finding the words, healing happens in layers, transforming, and support is crucial for healing. These survivors described their journey from survival to thriving, highlighting self-perception's key role and supporting symbolic interactionism as this study's framework. Mental health counselors and healthcare practitioners could facilitate social change by implementing mandatory comprehensive PTSD screening protocols for all patients.

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Dedication

I dedicate this paper to the countless women across the globe who have been overlooked, dismissed, ignored, misdiagnosed, misunderstood, and minimized. To grow up without a voice, without the essential support that fosters safety and belonging, is a profoundly difficult beginning to life. To navigate existence blindly, while those closest knowingly permit harm to persist against children, is an injustice that should never be tolerated in a society that calls itself civilized. Allowing young people to enter adolescence ill-equipped—unaware of the challenges ahead and lacking the skills necessary not only to survive but to thrive—is a systemic failure. It is a cruel setup, forcing individuals to struggle alone, overcoming one barrier after another, only to reach the starting line of adulthood and confront an even greater mountain to climb. Yet, with targeted education integrated into our schools and heightened awareness embedded within our social systems, we can empower children to help themselves, equipping them with resilience when there is no one at home or in their community to turn to. This research is dedicated to you. It is for my two resilient daughters, who will never endure such hardship because I have strived to shield them and provide the tools and knowledge I lacked in my youth. It is also for the seven brave participants who chose to share their story in this study, with the hope that they could help generations of women to come. Who will hopefully benefit from the transformative change spurred by this and continued research that demands accountability and systemic reform.

Acknowledgments

I wish to express my deepest gratitude to my two daughters for their unwavering patience and understanding as I dedicated countless hours at our table writing papers. I am profoundly thankful to Dr. Chavez Stuart for instilling confidence in me at the beginning of my doctoral journey and for her continued encouragement throughout my progression in the program. Additionally, I extend my sincere appreciation to all the professors who have contributed, however briefly, to my academic development; each has played a significant role in my growth. I am especially grateful to Dr. LeTourneau for her steadfast belief in my capabilities in advanced qualitative research and for making my decision in selecting a committee chair easy. Her guidance has been instrumental in navigating this process, alongside the strong support of Dr. Crayton, who has served as an invaluable co-chair. I take great pride in being surrounded by a community of intelligent, empowered women dedicated to uplifting one another's achievements. Prior to my experience at Walden, such a network of supportive women was absent from my world. I sincerely thank all of you for demonstrating that I am not alone on this journey.

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Chapter 1: Introduction to the Study

Introduction

The recognition of untreated trauma and posttraumatic stress disorder (PTSD) has become increasingly prominent within mental health research, driving efforts to raise awareness of its impact on women without adequate treatment. Experiencing prolonged, untreated PTSD or trauma can result in significant challenges for women, affecting their families and overall well-being. This is more apparent when a broad view of multiple fields is observed within the details of trauma literature. When a broad overview is conducted, discernible gaps in the realm of untreated trauma come to light and can help increase awareness of its impact on those who are living without proper treatment. While current literature has acknowledged these issues, there remains a need for further scholarly work specifically focusing on women and the profound mental, physical, emotional, and spiritual effects they endure. This widespread impact can lead to lost opportunities in professional, social, and financial realms, to name a few. This study examined narratives of women aged 40 to 60 who experienced prolonged, untreated trauma or PTSD that lasted more than a year and explored their journeys to potentially find suitable treatment and the subsequent transformations in their lives.

Background

Diagnosing untreated trauma or untreated PTSD poses significant challenges in mental health care (Ataria & Horovitz, 2021; Bailey et al., 2020; Bardeen, 2019; Barrett, 2024). Symptoms of untreated trauma can often mimic those of other mental health conditions, leading professionals to hastily conclude a diagnosis without thorough trauma

screening across various healthcare services, ranging from major surgery to routine annual evaluations (Boyer et al., 2022; Bruneau et al., 2020; Detert et al., 2019). Typically, untreated trauma is identified only after multiple unsuccessful diagnostic attempts, even when assessments are available (Owen, 2024), causing years of uncertainty and symptoms to escalate into co-morbid diagnoses (Margiotta et al., 2022). The inconsistencies in PTSD assessments and the healthcare system's insufficient emphasis on trauma exacerbate these challenges, as noted by Papachristopoulos et al. (2023). Moreover, factors such as cultural fluidity, communication barriers, and language differences, as highlighted by Drozdek and Moyene-Jansen (2020), persist as obstacles for women seeking treatment for PTSD or trauma. Mental health stigma, cultural biases, and societal perceptions related to being identified as a trauma or PTSD survivor further complicate the situation.

Jegari et al. (2023) provided a notable example of the challenges in obtaining an accurate PTSD diagnosis, highlighting issues such as cultural biases, inadequate assessments, frequent misdiagnosis, unethical practices, and over nine years of untreated trauma that adversely affected all areas of the participant's life, ultimately altering her life course. Although this example effectively illustrates global issues identified in the literature, it remains limited to the researcher's viewpoint. Furthermore, more studies regarding women within this population are needed to substantiate the experiences of individuals living with untreated trauma or PTSD.

Problem Statement

Women with untreated trauma or PTSD experience persistent symptoms, including, but not limited to, heightened co-morbid mental health issues, increased suicide ideation, interpersonal and intrapersonal difficulties, greater demand for medical care, and missed life opportunities (Spyska, 2023). These women's experiences and the effects of finally obtaining treatment have not been examined in this manner. Untreated trauma and PTSD can impact women at all phases of life, from childbirth to relationship violence, all the way to symptoms in older age that are misinterpreted as psychosis. Nevertheless, the healthcare system is not mandated to assess or evaluate for trauma or PTSD routinely. Each misdiagnosis or dismissal without adequate treatment can have profound and debilitating repercussions for future generations (Agha et al., 2024; Matoba, 2023).

A comprehensive review of social science research revealed limited results regarding the processes of these women as they seek care and attempt to manage symptoms, as well as the impact on their lives once they receive treatment. The scarcity of personal narratives about the critical role of accurate diagnosis, the benefits of early psychoeducation, and the importance of a supportive environment for post-traumatic growth (PTG) may hinder the awareness essential within the current healthcare system and the broader societal understanding of trauma-informed care and healing-centered engagement (Ellis & Wieling, 2024). Consequently, further research is essential to enhance understanding and bolster advocacy efforts to support this population.

Purpose of the Study

This qualitative study aimed to investigate the process of middle-aged women aged 40-60 who lived with prolonged undiagnosed PTSD or trauma for at least a year and analyzed how receiving appropriate treatment affected their lives. The results of this study have the potential to enhance awareness regarding the importance of trauma-informed or healing-centered engagement in healthcare strategies designed specifically for women managing undiagnosed PTSD or trauma. Such awareness could enable program facilitators to integrate the most effective modalities into their counseling practices. Although counseling programs are generally based on established theories, their execution can vary significantly. This project endeavored to identify and elucidate categories and connections to gain a more profound understanding of the processes experienced by women who have suffered from prolonged, untreated PTSD and trauma.

Research Questions

The research questions (RQs) for this study are as follows:

RQ1: How do women who have had prolonged undiagnosed PTSD experience the treatment process?

RQ2: How did treatment after prolonged undiagnosed PTSD influence their lives?

Theoretical Framework for the Study

Symbolic interactionism, as articulated by Charmaz et al. (2018), provides an abstract theoretical foundation for interpreting participants' data, emphasizing social interactions and ongoing processes through an individual's unique view of the world. From childhood to adulthood, each human constructs their distinct world lens as they

continuously receive and interpret data from their surrounding environment, resulting in a unique view of themselves and how they perceive they are seen in the world. Framing RQs and data analysis within the context of symbolic interactionism makes logical sense when addressing the profound impact of unaddressed trauma on an individual's worldview due to the unique way individuals internally process trauma (Ellis et al., 2022; Lee et al., 2022; Spytska, 2023), thus offering a robust and insightful framework for this study.

Constructivist grounded theory (CGT) was the methodology selected for this study. CGT builds on the methodology developed by Glaser and Strauss (1967), emphasizing an ongoing data collection and analysis process. The goal is to develop a theory emerging from the data rather than any preexisting theoretical framework (Charmaz, 2014). When using CGT, the researcher seeks to understand the world from the participants' experiences regarding a specific phenomenon. By collecting the participants' points of view, understandings, worldviews, and cultural backgrounds from this framework, new ideas and perspectives could emerge to help the current body of literature. The application of CGT, integrated with symbolic interactionism, aimed to explore the processes through interpreting narratives of women impacted by undiagnosed PTSD or trauma and how receiving treatment impacted their lives. This information provided significant insights into prevention and treatment, which could potentially transform perceptions and interactions while reducing undiagnosed cases and associated comorbidities.

Nature of the Study

The research design implemented in this qualitative study utilized CGT to address the RQs. This study's objective was to illuminate the processes of women who have endured prolonged undiagnosed PTSD or trauma and subsequently received treatment. A qualitative research approach was ideal for this study as it seeks to develop a theory drawn from the rich experiences of the participants (Charmaz, 2014). A quantitative methodology would have been unsuitable for this study due to its controlled conditions and fixed variables, which fail to capture the nuanced understanding of emotions and feelings necessary for these participants' narratives. By applying a qualitative design, the researcher was able to delve into participants' experiences within their natural contexts and vernacular. Expressing meaning was facilitated through intensive interviews, journaling, coding, and analyzing themes and patterns that emerged from the data (Charmaz, 2014). Charmaz (2014) explained that methodological processes delineate the practices researchers must employ to manage their research effectively and enhance their analytical prowess. CGT embraces the inductive, comparative, emergent, and open-ended methodology originally articulated by Glaser and Strauss (1967). The constructivist approach is applied in specific contexts that may be beyond our control or even unknown, wherein the researcher scrutinizes their perspective of the phenomenon and contributes to the identification of patterns and themes derived from the data. In this research, I aimed to explore the processes that women aged 40 to 60 went through who have endured prolonged, untreated PTSD or trauma before receiving treatment, and how the treatment

influenced their lives. Employing CGT enabled me to uncover their circumstances and identify data that could lead to developing a new theory.

Definitions

Complex post- traumatic stress disorder (C-PTSD): The diagnosis of C-PTSD includes the three core elements of PTSD, namely, re-experiencing traumatic events, avoidance of stimuli associated with these events, and a persistent sense of threat. Additionally, CPTSD comprises three other symptom clusters, representing chronic disturbances in self-organization, namely, a negative self-concept, emotional dysregulation, and interpersonal dysfunction. Typically, C-PTSD results from chronic trauma related to events such as repeated physical or sexual abuse, domestic violence, prolonged combat, torture, or genocide. However, an individual who has experienced repeated sexual abuse in childhood can develop PTSD, rather than C-PTSD, if they have protective factors, such as adequate caregivers or good social support. The reverse also applies; individuals exposed to a single traumatic event may develop C-PTSD if they have a poor social support network or a history of other adverse childhood events (Favaretto et al., 2022; Pinho et al., 2024).

Middle- aged women: Psychologist Daniel Levinson created a theory of adult development that describes growth based on age and stage of life. This theory is called the "seasons of life" theory. It asserts that people experience seven progressive stages in adulthood: early adult transition (ages 17 to 22), entering the adult world (ages 22 to 28), age 30 transitions (ages 28 to 33), settling down (ages 33 to 40), midlife transition (ages 40 to 45), entering middle adulthood (ages 45 to 50), and late adulthood (ages 50 and

above). Within each stage of life, adults experience two phases: a stable period, in which the elements of that particular stage are lived and experienced, and a transitional period, in which a person prepares to leave that stage and enter the next developmental stage (Schnyders, 2017). Midlife, according to The Midlife in the United States, focused on middle-aged adults and used the ages of 40-60 and pointed out that this is the time when most people make connections from their childhood, reflect, self-analyze, and make decisions on their future and the changes they want to make to improve their overall happiness (Lachman et al., 2015). Staudinger and Bluck narrowed their view of midlife by reviewing the literature and deciding on the ages of 40-60 (Staudinger & Bluck, 2001). For the scope of this study, middle-aged will be defined as 40-60.

Post-traumatic stress disorder (PTSD): PTSD (F43.10) can develop from exposure to or witnessing one or more threatening events or episodes of violence. The presence of intrusive symptoms, overwhelming feelings, and avoidance of trauma-related memories (World Health Organization, 2018) is an adaptive response of the psychic apparatus to excessive stress disorders, producing considerable subjective suffering. In 2018, based on clinical observations of individuals who have suffered multiple and/or prolonged traumas of an interpersonal nature throughout their lives, a new category for stress-associated disorders was included, namely (C-PTSD) (Favaretto et al., 2022).

Prolonged untreated PTSD or trauma: The current literature does not have a good measurement of how long untreated or undiagnosed trauma can go undetected and how much damage can be done during this unmeasured time. The current literature has used the language of “lifetime” (Li et al., 2023) and “childhood” (Ellis et al., 2022); Lee et al.

(2022) and individual case studies that found “5-12 years, Boyer et al., (2022), 20 years, Cooke & Shear (2001); Jegaral et al., (2023); and over many years”(de Oliveira et al., 2021) without proper diagnosis, uncovering a significant gap in the literature regarding the specific timeframe that defines prolonged trauma. For the scope of this study, prolonged PTSD or trauma will be defined as longer than 6 months.

Trauma: According to the DSM-5-TR, the word trauma includes disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion (APA, 2022). Therefore, throughout this paper, trauma will be used interchangeably or along with PTSD due to the ways it can be described within the literature.

Treatment for prolonged untreated PTSD or trauma: Any form of counseling, psychoeducation, outpatient or inpatient program, or online self-help applications that specifically assessed for trauma and gave treatment plans to the participant for a minimum of at least 6 weeks, with no maximum timeframe.

Assumptions

Participants were presumed to comprehend the Invitation to Participate (see Appendix A), Informed Consent, and the Interview Guide (see Appendix B) before engaging in a one-on-one interview and subsequent member check via Zoom. It was further assumed that participants were truthful in their self-reports regarding their age, experiences of prolonged trauma, or PTSD, and that they had undergone a minimum of 6 weeks of treatment specifically addressing their trauma or met any other criteria for eligibility in the study (see Appendix A and B).

Scope and Delimitations

The study's scope was to explore the process of women who have endured living with undiagnosed PTSD or trauma over an extended period and to assess how subsequent treatment affected their lives. Specific eligibility criteria for participants were established to ensure trustworthiness and credibility. Participants were required to be within the age range of 40 to 60 years old and must have identified as survivors of trauma. They needed to be willing to share their experiences of prolonged undiagnosed trauma and to have completed a minimum of six weeks of treatment for their trauma. Men were excluded from this study because its primary aim was to expand the existing literature on women and trauma; thus, including males was not suitable for this research. Researchers may customize their methodologies and participant selection in future studies to produce more generalized and transferable findings.

Limitations

In this study, participants were given the option to choose between in-person or online interviews, and they could have also elected to turn off their cameras during video sessions if it enhanced their comfort. The recordings captured only their voice, omitting facial images to ensure additional anonymity. Depending on the time elapsed since their initial trauma experiences, there may have been occasions where participants recalled events only to the best of their knowledge, potentially introducing respondent bias during data collection, which might have affected the interpretation of the outcome. The study employed checklists and guidelines to address potential limitations and research biases (see Charmaz & Thornberg, 2021), such as the researcher striving to achieve

methodological self-consciousness and having an open, non-committal, critical, and analytic view of the existing literature of the field. I followed the process of CGT: initial coding (whether word by word or line by line), memo writing (either clustering or free-writing), journaling, coding for topics and themes or gerunds, constant comparative methods, focused coding, and axial coding, as described by Charmaz (2009). Checklists and guidelines were intended to validate the participants' responses by testing the data's validity and drawing from diverse sources and methods (see Charmaz & Thornberg, 2021).

Significance

Current literature has acknowledged undiagnosed PTSD and trauma (Agha et al., 2024; Barrett & Currin, 2024; Li et al., 2023; Vogt, 2024), highlighting the substantial lack of diagnosis and the underreported prevalence of undiagnosed PTSD. However, there exists a gap in research explicitly examining the transformative process of obtaining treatment and its impact on individuals' lives. This study aimed to explore the process through the narratives and natural language of trauma survivors, emphasizing the significant positive effects that appropriate trauma treatment can have on a person's life trajectory. While existing literature within the healthcare domain underscores the necessity for trauma-informed care and healing-focused engagement, there is an absence of research centered on middle-aged women who have survived the process and endured prolonged, untreated trauma. It is imperative to move beyond mere statistics and delve into personal narratives to understand the implications and harm caused by a lack of treatment on individuals, their families, and their overall well-being (Al et al., 2021;

Barrett & Currin, 2024; Favaretto et al., 2022; Quinones et al., 2022). This study endeavored to bridge the knowledge gap by identifying critical patterns or themes that professionals should focus on for accurate trauma assessment and identifying the most effective treatments, thereby reducing the number of individuals living with untreated trauma due to systemic deficiencies (Smith et al., 2020), cultural biases (Mekawi et al., 2021; Thomas et al., 2019), or social perceptions (Stirbys, 2021).

This study, along with analogous research in the field, has the potential to significantly enhance and transform the lives of women who have lived with untreated PTSD and trauma, as well as prevent younger women from lacking adequate assessments that could lead to untreated trauma. Ultimately, the possible outcomes may (a) motivate educational and government bodies to integrate early psychoeducation on PTSD or trauma within educational and healthcare systems; (b) necessitate that the healthcare system implement routine screenings for PTSD and trauma in all patients; (c) diminish bias and enhance education and training in graduate and doctoral programs and internships for counselors and physicians, emphasizing the critical importance of trauma assessment.

Summary

This chapter offered foundational insights into the issue of undiagnosed PTSD and trauma in middle-aged women. It underscored the significance of understanding the process of these survivors through a qualitative lens, particularly in terms of receiving treatment, its impact on their lives, and the potential for this research to drive social change. The RQs, detailed explanations, and the theoretical and conceptual framework

underpinning the study are included. Definitions of key terms, along with the assumptions and limitations/delimitations, are also outlined. This chapter represented an overview of the study, where Chapter 2 discusses the literature that supports the study's rationale, theoretical perspectives, methodology, and research design.

Chapter 2: Literature Review

Introduction

In Chapter 1, I provided an overview of the current study, which involved investigating the necessity and rationale for examining how women who have endured extended periods of untreated trauma navigated the process of finally receiving treatment and the subsequent effects on their lives. In Chapter 2, I present current literature pertinent to this subject, including studies aligned with the chosen methodology that correspond with the study's scope. This chapter also explores specific categories of women that have been studied in-depth, offering supportive information while simultaneously revealing inherent limitations due to the narrow focus of the studies concerning women with prolonged, untreated trauma. The justification for the concepts this study uncovered is articulated and explained, highlighting what has been found, what remains to be explored, and the underlying themes within the research articles. Chapter 2 reviews and synthesizes the significance of the selected RQs and why CGT, combined with symbolic interactionism, provides a meaningful framework.

The study of PTSD has gained increasing attention in recent years, especially as awareness grows regarding its prevalence beyond traditional contexts like combat zones. Despite this progress, the accurate diagnosis and treatment of PTSD, particularly among women who have experienced prolonged, untreated trauma, remain significantly challenging. This research aims to delve into the processes of middle-aged women who have lived with undiagnosed or misdiagnosed PTSD for at least a year, exploring how the eventual receipt of appropriate treatment impacts their lives. By employing CGT and the

lens of symbolic interactionism, this study aimed to uncover the nuanced processes these women undergo, highlighting the critical need for trauma-informed care. Through a comprehensive review of current literature, this dissertation not only addresses the gaps in understanding the impact of untreated PTSD on women but also underscores the potential for developing more effective healthcare interventions. Ultimately, this research aspires to contribute to a more empathetic and precise approach to diagnosing and supporting women dealing with PTSD, offering insights that could transform both clinical practices and policy frameworks.

Literature Search Strategy

The databases utilized for the search of pertinent and recent literature encompassed MEDLINE/PubMed, CINAHL, APA PsycInfo, APA PsycArticles, SocIndex, ScienceDirect, Academic Search, Social Sciences Citation Index, Education Source, ERIC, IEEE Xplore, Emerald Insight, Directory of Open Access Journals, and Google Scholar. The search was confined to peer-reviewed academic journals within the last five to six years. Key terms employed included *PTSD or post-traumatic stress disorder or post-traumatic stress disorder or post-traumatic stress disorder AND undiagnosed or misdiagnosed or not diagnosed (all text) (405 results*), with the limitations of peer-reviewed and a 5-year history, reduced these to 356. Then I added AND *women or female or gender (all text)*, which provided 294 results. Finally, I added - AND *cognitive or reflection (all text),* which reduced the dataset to 203 results. The peer-reviewed literature discussed in this paper is no older than 5 or 6 years prior, except where foundational works warrant citation. This review of the current literature offers

insights into the existing professional understanding of the subject while highlighting the remaining gaps that must be addressed to enhance support for this demographic.

Theoretical Foundation

Symbolic interactionism served as the theoretical framework through which I engaged with the emerging data. As Charmaz et al. (2018) articulated, symbolic interactionism provides an abstract theoretical foundation of premises and concepts essential for understanding social realities. This perspective allows the researcher to interpret data from participants in a manner that emphasizes their processes and interactions with their environment, focusing on how they execute these activities. Symbolic interactionism offers a research context that examines how social interactions from childhood to adulthood influence our worldview and shape our interactions. Given the impact of unaddressed trauma on an individual's perspective – from early childhood into adulthood (Ellis et al., 2022; Lee et al., 2022; L. Spytska, 2023), symbolic interactionism offered a robust framework to underpin this study. The lens of symbolic interactionism guided the formulation of questions and established the foundation for the data that were analyzed to develop a possible theory (Charmaz, 2014).

Literature Review Related to Key Variables and/or Concepts

In this section, I provide an in-depth discussion of an overview of the most recent studies related to the prolonged misdiagnosis of women and how the process of eventually receiving treatment significantly affected their lives. The broader scope of the study included examining a wide variety of different methods, distinct subpopulations, and specific focuses that are centered on trauma due to how the current literature

typically approaches untreated PTSD or trauma. This dissertation delved into the complex processes of women who have endured prolonged symptoms of PTSD and have subsequently undergone treatment. Within the scope of this research, "women" refers to all individuals who self-identify as female, aged between 40 and 60 years, encompassing all races, ethnicities, countries of origin, and other diverse aspects of cultural identity. Undiagnosed, untreated, and misdiagnosed PTSD and trauma will also be used interchangeably at times due to the breadth of the articles and the outcomes being similar. This section provides an in-depth analysis of the specific subpopulations of women for whom existing literature has gathered substantial and insightful information, the various barriers impeding access to treatment, and the detailed treatment process once it is initiated. Examining these critical points is crucial for a comprehensive understanding of these women's formidable journey in their pursuit of mental well-being within the current healthcare system and societal frameworks. As the literature suggests, this population has been studied broadly and quantitatively. However, minimal personal impact statements regarding the process to proper diagnosis and beyond, in their own words, have been collected.

Globally Unaddressed or Untreated PTSD and Trauma

Despite the increasing awareness of PTSD within the general public and progress in recognizing that PTSD or trauma can occur outside of war zones, significant challenges remain in preventing the misdiagnosis or undiagnosed PTSD (Agha et al., 2024). An alarming global crisis is the undiagnosed or misdiagnosis of PTSD, particularly concerning its effects on women (Barrett & Currin, 2024). Untreated PTSD

or trauma represents a global challenge that, with proper intervention, can be managed effectively (Agha et al., 2024). Vogt (2024) indicated that 9.7% of the women in the United States experience PTSD, while also disclosing that most women will not disclose or seek help. The World Health Organization's (WHO) World Mental Health Survey, conducted across 24 countries, revealed that around 70% of the global population has experienced at least one traumatic event (as cited in Li et al., 2023). While many people process these traumas and recover, the lifetime prevalence of PTSD in the global community is 3.9%. Higher-income nations reported PTSD rates twice as high as those in upper-middle-income countries. The existing research (Bruneau et al., 2020; Cogan et al., 2021; Ellis et al., 2019; Jegari et al., 2023) addressed the misdiagnosis and untreated PTSD prevalent across the global population and healthcare spectrum, encompassing various cultures and subcultures of women with prolonged undiagnosed PTSD and trauma. Making this population's words and feelings regarding the process of finding help and finally receiving proper treatment an important voice that should be acknowledged through a qualitative study.

Research utilizing machine learning by Gagnon-Sanschagrin (2022) identified that 50,000 out of 2,074,471 U.S. patients were labeled as having PTSD based on machine data, despite lacking an official diagnosis and corresponding treatment, which means that artificial intelligence, or machine analysis, was able to identify terminology that indicates a PTSD diagnosis from the patient's charts. Additionally, prior co-morbid diagnoses were evident in the data. The findings revealed that the individuals with undiagnosed PTSD faced higher healthcare expenses, amounting to $11,156 to $11,723

more than those without PTSD over 6 months. Margiotta et al. (2022) found that at the state level, in Texas, at least one in eight pregnant and postpartum women went undiagnosed and untreated for PTSD, which resulted in costs of $44,000 per affected mother-child pair over six years. This average is higher than the national average of $32,000. The productivity losses for this population were $610.2 billion, and non-obstetric health expenditures of $445.1 million, to name a few of the costs related to untreated maternal mental health conditions, for one state. Beyond healthcare costs, persistent misdiagnosis can severely impact their mental health, family relationships, financial status, and societal productivity (Gagnon-Sanschagrin, 2020). For instance, da Silva et al. (2019) found that out of 200 patients, 41, or 20.5%, fulfilled the criteria for PTSD diagnosis, with 80% of those patients being women who were initially misdiagnosed. Barrett and Currin (2024) found in a mixed-method study that PTSD has diverse effects on subcultures and populations worldwide without prejudice in its effects. Each cultural or demographic group encounters a population that brings forth its negative stigma, shame, and fear concerning the disclosure of trauma, which can aggravate co-morbid symptoms and hinder the delivery of appropriate treatment (Patel et al., 2022; Saraiya et al., 2021). Understanding their experiences and the unique challenges they face may reveal crucial insights into the underlying factors contributing to living with untreated trauma, ultimately guiding more effective interventions tailored to diverse populations.

Johnson et al. (2020) discussed the COVID-19 Pandemic as having notably raised global awareness regarding the nature of trauma and PTSD, thereby broadening the

perception that these conditions are not exclusive to individuals with preexisting mental health issues. However, one significant drawback was the immense pressure exerted on the healthcare infrastructure and the frontline personnel. This crisis spurred the development of a substantial body of empirically validated research on PTSD and trauma. According to Wojtysiak and Zielińska-Więczkowska (2022), frontline medical staff worldwide experienced heightened levels of anxiety, depression, stress disorders, sleep deprivation, and other psychological conditions that look like trauma or PTSD. All at once, the importance of mental health support was underscored to ensure the safety and well-being of the medical professionals managing the overwhelming patient load during the pandemic. The researchers employed the term ‘combat stress’ to characterize the impact of COVID-19 on these workers, and it is pertinent to recognize that similar stress was experienced across households, businesses, and various demographic and cultural groups across the spectrum (Menculini et al., 2021). This new awareness of what trauma can be will hopefully force the same healthcare providers who experienced these symptoms to assess for trauma and PTSD in their patients to prevent untreated trauma from continuing to prevail.

As traumatology advances, both researchers and practitioners are expanding the definition of a traumatic event to enhance conceptualization and treatment purposes. This new definition ensures expanded understanding and characterizes an event as traumatic if it is highly distressing, temporarily overwhelms an individual's coping mechanisms, and results in enduring psychological effects (APA, 2022; Krzemieniecki, 2022). The literature has spanned numerous topics and populations, so the impact of misdiagnosis

and trauma may appear isolated until viewed from a broader perspective. The current literature has illustrated untreated or misdiagnosis of PTSD among women in various contexts, including (but not limited to) refugee women from Syria at risk of diabetes and potential screening (Agha et al., 2024; Magwood et al., 2022; Venkatachalam et al., 2023), women in or formally in the military (Barrett & Currin, 2024; Maunder 2022), parents of European war veterans (Leshem et al., 2023), clinical care settings in Canada (Fearon et al., 2024; Wojcik et al., 2022) and in England (Cooper et al., 2023), women with postdelivery PTSD, postpartum mood, and anxiety disorders with missed screening opportunities (Bartal et al., 2023; Beck, 2023; Margiotta et al., 2022, Padin et al., 2022), racially minoritized patients (Jegarl et al., 2023), older adults and women (Kernohan et al., 2023; McIntosh et al., 2022), hospitalized COVID patients and healthcare services (Katarzyna & Zielinska-Wieczkowska, 2022; Lucijanic et al., 2023), perspectives of general practitioners on managing untreated mental health disorders (Papachristopoulos et al., 2023), lower emotional awareness (Smith et al., 2023), PTSD and increased risk for ADHD (Wendt et al., 2023), higher risk for obstructive sleep apnea and substance use (Colvonen et al., 2022), undiagnosed PTSD and depression (Hong et al., 2022), female college students in Korea Lee et al., 2022), France (G. Pais et al., 2021), and America (Poindexter et al., 2022) with PTSD, interpersonal trauma and their coping skills, undiagnosed mental illness and HIV in Durban, South Africa (Naidoo et al., 2022), and caregivers in Northern Ireland with undiagnosed PTSD (O'Neill et al., 2022), as well as anxiety, PTSD, insomnia and fibromyalgia in women from Jordan (Al et al., 2021). This body of work is merely a sample of an extensive collection of literature discussing the

dangers of undiagnosed PTSD in women and highlighting its global impact. While many studies have emphasized the detrimental effects of untreated PTSD and trauma over the long term, few have explored how the experience affects women in their own words. There is a notable lack of qualitative research reflecting the personal impact of living with untreated PTSD on women and their efforts to achieve wellness.

Implications for Women Living With PTSD Remain Unaddressed

To gain a comprehensive understanding of the consequences when women experience extended periods without an accurate PTSD diagnosis, an essential review of the literature across diverse fields is necessary, as trauma can manifest in various contexts and times. When trauma remains untreated, there is an increased risk of developing further mental health disorders, which can progressively worsen. This risk includes symptoms such as flashbacks, somatization, self-critical emotions, disturbances in interpersonal relationships, escalating conflicts, deterioration of psychological resilience, employment of defense mechanisms, lower schooling, and challenges in social interactions, to name a few (Al et al., 2021; DeTore et al., 2021; Favaretto et al., 2022). Many healthcare systems and professionals fail to conduct thorough assessments or address PTSD or trauma with requisite seriousness (Auxemery, 2021; Cogan et al., 2021). Consequently, the underdiagnosis of PTSD has become a Global problem (Ellis et al., 2022; Tully et al., 2021).

The overlapping symptoms of mental health disorders, such as anxiety and depression, often cause PTSD symptoms to be misidentified or simultaneously present with other conditions, leading to neglect in PTSD screening and treatment. In contrast,

other mental health issues are diagnosed and managed instead (Agha, 2024). Furthermore, Quinones et al. (2022) highlighted that women who endure prolonged periods without PTSD or trauma treatment are at an elevated risk for co-occurring mental health conditions, earlier-onset dementia, cognitive complications later in life, developmental impairments in their children, and other adverse outcomes. It emphasizes the importance of accurate trauma assessment and trauma-informed care, which can have a transformative impact on these women's lives (Jegari et al., 2023). Understanding women's experiences and the obstacles they encounter when seeking help can be immensely valuable for healthcare professionals to understand the harm caused by not completing a 5-minute assessment.

Barriers to Diagnosis and Treatment

Vasconcelos et al. (2023) highlighted the ongoing adaptations in the DSM-5 and the ICD-11 definitions of PTSD, underscoring the controversy over which assessment tool best measures the condition. This lack of standardization contributes to the absence of a universal scale in the health care assessments if such a scale is used. Specifically, women with PTSD or trauma often continue their lives without adequate assessment, enduring severe physical, emotional, financial, and personal consequences. Li's (2023) meta-analysis review indicated that untreated PTSD significantly elevates the risk of physical diseases, co-occurring mental disorders, mortality, accelerated aging, and its transgenerational transmission. Due to the stigma surrounding the reporting of traumatic events, such as interpersonal violence, many women do not seek assistance for their symptoms, causing reported figures to underrepresent the real impact of undiagnosed

PTSD and trauma (Patel et al., 2022; Plante et al., 2021). Current research indicated that only 11% of adult patients in primary care who met the diagnosis criteria for PTSD have an officially recorded diagnosis (Gagnon-Sanschagrin et al., 2022).

Unaddressed or Unrecognized PTSD and Trauma in Women During Prepartum and Postpartum Periods

A significant focus of research within the domain of undiagnosed PTSD and trauma is within the population of women who experience trauma during childbirth, which remains primarily unrecognized by the healthcare system, mainly affecting women of color in the United States (Krzemieniecki, 2022; Patterson et al., 2019; Pilav et al., 2022). The issue of undiagnosed PTSD, along with other comorbidities during the transition to motherhood, presents a public health challenge; one in five women encounters difficulties during this phase, yet their conditions frequently go undetected and untreated. The cost of untreated postpartum mental health disorders was estimated to be approximately $14 billion from the 2017 cohort, from conception to 5 years postpartum, not including the significant costs related to decreased economic productivity among affected women (Margiotta et al., 2022).

Mental health issues related to maternal health are the leading complications during childbirth and significantly contribute to maternal mortality (Bartal et al., 2023). Minority ethnic women face considerable barriers to accessing healthcare services both during pregnancy and in the postpartum period (Pilav et al., 2022). Symptoms stemming from these issues can lead to both emotional and physical neglect of the child and substantially increase pediatric healthcare costs.

Although some healthcare facilities screen for postpartum depression, an official assessment for PTSD and trauma is not routinely recommended. Beck (2023) found that only 31% of women suffering from postpartum mood disorders are recognized in clinical settings. Additionally, 44% of women reported perceiving their births as traumatic, which can result in long-term adverse outcomes such as PTSD, challenges in mother-infant interactions, and breastfeeding difficulties. Even if the assessments are conducted after the onset of pregnancy, treatment remains effective in alleviating symptoms (Amer et al., 2024).

The investigations conducted by Bartal et al. (2023) employing mixed methods and by Beck (2023) using qualitative approaches have been instrumental in unveiling previously undiagnosed PTSD among women. These studies correlating women's narratives of their childbirth experiences with PTSD screenings revealed that those with traumatic experiences tended to produce lengthier narratives and exhibited a higher frequency of negative emotional expressions, anger, and words associated with death. These patterns were identified through natural language processing (NLP). Additionally, metaphors emerged as a notable means through which women could articulate their PTSD, particularly since some may lack the precise vocabulary to convey their emotions and experiences fully. With open-ended surveys, Keedle (2022) found that poetry inquiry also helped women express their experiences of traumatic birth, showing consistent relations between the use of language or expression of feelings to reduce symptoms of trauma. This research underscores the significance of understanding communication

styles, linguistic nuances, and the value of narrative feedback in assessments, moving beyond simple checklists to identify women who may be suffering from trauma.

Krzemieniecki (2022) has highlighted the scarcity of counseling literature addressing treatment recommendations for women experiencing trauma after childbirth. This oversight is emphasized by Padin et al. (2022) as particularly troubling given the well-established consequences of untreated maternal health issues on mothers, infants, and families, as well as the frequent misdiagnosis and mismanagement of postpartum PTSD, often mistaken for postpartum depression. Additionally, women who perceive their childbirth as traumatic often report experiencing authoritative interactions with medical personnel, characterized by dismissive attitudes, contradictory advice, and insufficient information regarding possible injuries, which intensify feelings of helplessness and loss of control. Currently, no standardized protocol exists for screening childbirth PTSD (CB-PTSD), resulting in women with undiagnosed PTSD being discharged with their newborns, potentially ill-equipped to handle the emotional demands of motherhood (Patterson et al., 2019). This issue is often compounded by healthcare staff's handling of follow-up visits, where women may feel stigmatized for exhibiting such symptoms and find the time for a comprehensive trauma assessment lacking. The absence of trauma-informed care awareness for undiagnosed or untreated PTSD heightens the likelihood of trauma being transmitted to the children of these women, thereby impacting future generations, which is a prevalent theme in the existing literature.

The Ramifications of Unaddressed PTSD or Trauma Manifest as Generational Trauma

Generational trauma, a significant social issue examined by Matoba (2023) in sociology, is analyzed through the perspective of symbolic interactionism in the current study. Matoba posits that collective cultural trauma occurs when a substantial group experiences a profound loss, feeling so profoundly victimized and powerless that these experiences become integral to their identity. Collective and historical trauma pertains to the enduring consequences of severe, unresolved trauma endured by families, groups, or communities, which is transmitted across generations. The literature discusses topics such as PTSD and trauma associated with war-torn regions, focusing on the impact on individuals forced to flee, become refugees, and start anew. Within the discourse of undiagnosed or untreated PTSD or trauma, generational trauma is recognized for its potential to affect families for multiple generations. It manifests in families by transferring trauma symptoms, emotions, and events to offspring and other relatives (Merten et al., 2021). Generational trauma often reveals itself through parenting challenges, marital conflicts, dysfunctional communication, depressive symptoms, and antisocial or other personality issues in children (Agha et al., 2024), among others. Matoba (2023) also emphasized the pivotal role of language as a tool for expressing trauma and as an essential instrument in trauma comprehension and treatment. Like Bartal (2023) and Beck (2023), Matoba evaluated and measured the observed thoughts, cognition, participants' thoughts, cognition, emotions, feelings, and bodily sensations as they narrate their experiences. Matoba (2023) referenced larger historical groups, such as

Holocaust survivors, enslaved individuals, and women, highlighting how undiagnosed or untreated PTSD creates a 'trauma bond' within families, children, loved ones, and friends, inadvertently maintaining and spreading trauma within the family unit. This narrative becomes intertwined with the family's history and identity, thereby impairing the family's capacity for resilience and progress.

The consequences of untreated PTSD are explored within the immigration context, highlighting themes such as self-impact, couple dynamics, parent-child relationships, and mental health stigmas, with effects still observed four generations later (Mak & Wieling, 2024). The enduring impact of generational trauma, as noted by Chase (2018) and Giesbrecht et al. (2022), is evident in populations like the Aboriginal people of Canada, who often refuse medical assistance and endure untreated suffering, especially indigenous women who have suffered from domestic violence (DV). This reluctance is rooted in historical distrust of healthcare providers, leading many Indigenous Canadians to forgo some of the best healthcare available globally. The prolonged number of populations affected by untreated trauma; current literature offers limited guidance on optimal treatment scenarios for trauma survivors. However, a recognized need is further mixed-method or qualitative research focusing specifically on women to amplify community perspectives. (Nilaweera et al., 2023).

Cultural Biases and Unaddressed PTSD and Trauma

Jegaral et al. (2023) highlighted that integrated healthcare teams enhance patient care. However, a literature review covering the period from the 1980s to the 2010s indicated that African American patients were up to four times more likely and Latino

American patients were up to three times more likely to receive a diagnosis of primary psychotic disorders compared to white Americans. Racialized misdiagnosis constitutes an additional violation of justice, as minoritized patients, upon accessing limited psychiatric resources, face further failure through biased diagnosis practices. Halstead (2021) found that the complex ways in which people of color encounter traumatic events challenge "Criterion A" DSM-5 PTSD qualification, prompting debates on the legitimacy of recognizing racism and oppressive acts as criteria for a PTSD diagnosis. Quantitative evidence has indicated that microaggressions, discriminatory racial environments, and social inequalities adversely affect mental health, leading to trauma symptoms.

Jegaral et al. (2023) discovered that healthcare providers are more likely to assign a diagnosis of schizophrenia and/or schizoaffective disorder based on race more than any other demographic factor. This disparity remains even when there are no differences in clinician symptom evaluations. Their case study involved a woman of color who was racially misdiagnosed with schizophrenia, illustrating how interdisciplinary, health equity-oriented providers collaboratively re-evaluated her condition, leading to a culturally informed diagnosis of major depressive disorder and PTSD. By listening to the patient's narrative, including how she was triggered two years prior while working and experiencing distress and intrusive thoughts related to past traumas, clinicians gained insight into the dynamics of iatrogenic racism and the presence of inequitable biases within clinical practice. Halstead (2021) shared the case of a 58-year-old African American woman who sought treatment after going on disability due to workplace discrimination. Diagnosed with C-PTSD, she had spent years in conventional therapy

with minimal progress. Her symptoms included hypervigilance, intense recollections, and anxiety, alongside a secondary diagnosis of persistent depressive disorder with ongoing suicidality. After years of ineffective relief, she considered ketamine-assisted psychotherapy. However, another African American woman described by Cook and Shear (2001) was misdiagnosed for over 20 years and was finally correctly diagnosed and provided proper treatment. Despite its age, this article remains pertinent due to the lack of progress over the past 23 years in effectively assessing PTSD, particularly among individuals from cultural minorities and lower socio-economic backgrounds (Dale et al., 2021).

Labash (2021) explored the assessment of trauma in Latina patients, noting that more than 50% of Latina women experience interpersonal violence (IPV). Barriers such as financial constraints, lack of health insurance, limited English proficiency, insufficient awareness of supportive resources, and higher self-reliance hinder access to healthcare. Cultural factors, including machismo and familismo, also influence these women's willingness to seek assistance. For this demographic, co-located healthcare providers and counselors are vital, given the association of elevated suicide ideation and somatic complaints with trauma.

Women in the Military

Over the past 15 years, the United States Department of Veterans Affairs has been striving to provide effective treatment for PTSD, focusing on prolonged exposure therapy (PET) and cognitive processing therapy (CPT) (Kehle-Forbes et al., 2022). However, a concerning trend has emerged, with over 60% of veterans who begin these therapies

dropping out, leaving many veterans without the necessary support for their PTSD. A qualitative study by Kehle-Forbes et al. (2022) revealed that the language of the veterans who completed the therapy, as compared to the veterans who did not, highlighted key differences. Those who felt supported and involved in their treatment plan were more likely to complete the program, while veterans lacking a rapport or therapeutic alliance with the therapist were more prone to discontinue treatment. Establishing a treatment-specific therapeutic approach was identified as a significant factor in program completion.

Peters (2021) discovered that, compared to men, women often experience unique traumas, such as sexual assault, at higher rates and younger ages. Women are more vulnerable to developing PTSD after trauma exposure and tend to report a greater number of PTSD-related symptoms. Jiang et al. (2021) found that women report higher levels of specific PTSD symptoms, such as exaggerated startle response and increased physiological reactivity to trauma-related cues (triggers). Additionally, Martin et al. (2021) found that some female veterans who participated in a national VA survey and had past or present sleep apnea diagnoses were found to have undiagnosed PTSD.

Detert et al. (2019) emphasized that many veterans with undiagnosed PTSD face barriers to obtaining care, suggesting the creation of a straightforward process for civilian primary care providers to help identify undiagnosed PTSD. The culture of the military and a lack of understanding of military terminology by most civilian healthcare providers contribute to veterans' reluctance to disclose PTSD symptoms. Furthermore, most healthcare providers lack formalized training in treating the veteran population or trauma,

complicating accurate assessment. The study found that veterans prefer paper-based screening, want referrals to be made via email to providers trained in counseling military veterans, and prefer PTSD assessments to occur only during annual wellness visits. Due to the rising number of women now involved with the military and the rates of suicidal ideation that is reported due to military sexual assault, discovering the process that women endure while living with undiagnosed trauma, especially within this population, would help advocate for increasing awareness and preventing those who choose to serve our country from dropping out of sight from society and their lives and ultimately attempting or completing suicide (Kahn et al., 2019).

Manifestations of Unaddressed Psychological Trauma

Spytska (2023) identified that undiagnosed trauma can significantly alter life perspectives, leading to a more harmful or fatalistic outlook, diminishing enthusiasm, and reduced engagement with daily life. This trauma disrupts cognitive processes necessary for envisioning a positive future, as the underlying fatalistic thinking prevails. Due to untreated trauma impacting various personality structures, such as motivational, volitional, emotional, and self-esteem, affected individuals must receive treatment to facilitate post-traumatic growth. Ataria and Horovitz (2021) concurred with Spytska (2023), discussing the effects on individuals who endure prolonged, repeated trauma, which can harm essential mechanisms like the minimal self (MS), potentially resulting in conditions such as complex PTSD (CPTSD) and schizophrenia. For instance, individuals in such situations may develop dissociation as a protective mechanism for MS. However, some individuals either cannot disassociate or become within the disassociation, unable

to return to their sense of self, thus manifesting symptoms akin to schizophrenia. Notably, 30% of patients diagnosed with schizophrenia or schizoaffective disorders test positive for PTSD, which is threefold the incidence in the general population. Additionally, over 50% of incarcerated individuals report experiencing at least one form of childhood abuse, underscoring the imperative need for early trauma assessment and intervention (Bailey & Brown, 2020).

Boyer et al. (2022) highlighted that some women spend 5 to 12 years entangled in the treatment process before being correctly diagnosed with PTSD, including dissociative symptoms. Advances in neuroimaging are aiding in elucidating PTSD by examining structural and functional brain alterations in those with dissociative disorders. Boyer et al. (2022) argued that with appropriate training, women living with untreated trauma can reduce symptoms, health and social risks, and overall healthcare costs. This study indicated that effective disassociation treatment through modalities such as prolonged exposure therapy, cognitive processing therapy (CPT), dialectical behavior therapy (DBT), Internal Family Systems (IFS), Eye-Movement Desensitization and Reprocessing (EMDR), or sensorimotor psychotherapy, alongside adjunctive medications, can achieve a 25-64% reduction in symptoms, yielding significant economic benefits for both the women and society. Nilaweera et al. (2023), in a meta-analysis, identified a gap in the literature, emphasizing the need for more studies on women and PTSD, as women are substantially more susceptible to PTSD and have an elevated risk of increased mortality. Of the 30 reviewed articles, encompassing 2.1 million participants, only one focused exclusively on women. Lie et al. (2023) discovered that women with untreated PTSD

experienced deteriorated cognitive functioning and accelerated cognitive decline over six years compared to those who received treatment—the latter group showed a return closer to their baseline cognitive function.

Obstacles to Treatment

Misdiagnosis

The existing literature has highlighted several challenges that healthcare professionals face when diagnosing trauma or PTSD. According to Bailey and Brown (2020), the latest edition of the DSM does not directly include a diagnosis for complex traumatic stress disorder or its association with dissociation, despite the recognition by the WHO in 2018. Recent studies have underscored the association between untreated PTSD and the progression from initial episodes of psychosis (DeTore et al., 2021) to persistent symptoms of Schizophrenia (Ataria & Horovitz, 2021). There is a growing body of evidence highlighting instances where women's expressions of distress are misattributed to depression or anxiety within the healthcare system, leaving PTSD unrecognized. Fearon et al. (2024) have scrutinized the prevalent misdiagnosis concerning trauma in clinical settings. PTSD frequently coexists with other psychiatric disorders, with a comorbidity rate ranging from 62% to 92%, and often reveals a neurobiological susceptibility linked to substance use disorders, as indicated by abnormal activity in neural structures in the amygdala, hippocampus, and hypothalamus. Despite the detectable overlap, many substance use treatment facilities neglect to assess for PTSD, and even when comorbidity is identified, there is often a lack of integrated treatment approaches. Even if patients do not fulfill the criteria for a trauma diagnosis,

the neurobiological impact of repeated traumas can manifest in elevated physiological states, such as reduced cortisol levels or hyperactivated sympathetic nervous systems.

Numerous studies by Cooper et al. (2023), Hatch et al. (2020), Korman et al. (2019), and Marafini (2020) have individually examined whether individuals recovering from critical surgery or illness continue with untreated trauma post-treatment. Hatch et al. used a postal questionnaire to identify the burden of psychopathology among survivors of critical illness, which would otherwise remain undiagnosed post-discharge from an ICU. Upon being informed of psychological symptoms, general practitioners initiated treatment in 27% of cases and increased surveillance in 18%. This study was the first to describe the management of PTSD, anxiety, and depression identified via a postal survey of critical illness in survivors. Nearly one-fourth of patients reported symptoms of anxiety, depression, and PTSD following critical illness, with a psychological diagnosis predating the initial (3 months) questionnaire. These results were known before notifications were sent to the general practitioners, so the study could not have influenced diagnosis. However, a significant portion (27%) received medical intervention or specialist referral among those without a pre-existing diagnosis. Without these notifications, some patients might have consulted their general practitioners eventually, yet the notifications likely expedited treatment. Even though the current literature finds many instances where trauma is ignored, there has been little change within the healthcare system to prevent these instances from happening.

Assessment

The disparities in assessment tools and the criteria for PTSD between the DSM-5 and others, like the LEC-5, contribute to some patients being overlooked and untreated. Bardeen and Benfer (2019) discovered that the inability to identify individuals with a history of trauma exposure using the worst-event method could have profound implications for those suffering from psychopathology. Incorporating a written narrative alongside this assessment can help meet the PTSD criteria, thereby facilitating appropriate treatment. Cogan et al. (2021) also identified that introducing a timeline for the onset of symptoms could aid in distinguishing between bipolar disorder and PTSD. The age demographic of the study, which involves women aged from approximately 34.94 to 35.6 years, aligns with this research. More than half of the participants who initially did not meet the PTSD criteria met the criteria after completing the self-reported narrative. Alternatively, Artificial Intelligence (AI) technologies can be helpful when identifying PTSD or trauma quickly if the healthcare system incorporates the AI review as part of procedures. Gagnon-Sanschagrin (2022) and Jiang (2021) found that machine learning can help healthcare providers detect PTSD faster by quickly reviewing symptoms with new automated intelligence technologies.

The omission of trauma assessment is recurrent in the literature, leading to prolonged undiagnosed trauma that exacerbates symptoms and complications over time. Previous research has illustrated that environmental factors influence women's decisions to seek help for trauma (da Silva et al., 2019; Detert et al., 2019; O'Neill et al., 2022). If healthcare providers are not going to assess for trauma or PTSD, this could send a

message to the patient that it is not important. Research studies have demonstrated that incorporating trauma and PTSD assessments into annual wellness checks requires minimal additional time if healthcare staff are adequately trained. Furthermore, PTSD and trauma are notably prevalent yet frequently overlooked in outpatient healthcare settings. Jiang (2021) investigated methods to reduce PTSD assessment completion time, facilitating healthcare providers' ability to diagnose PTSD and administer effective treatment accurately. This shortened assessment, maintaining a .90 on all diagnostic classification measures, could serve as an alternative for those lacking trauma assessments. Although the study noted that dissociative reactions were among the questions that could be omitted to expedite the trauma assessment, contradicting current literature that highlights dissociation as a commonly overlooked PTSD symptom (Boyer et al., 2020), the shortened assessment for providers is expected to encourage the adoption of trauma assessments. Reportedly requiring only two additional minutes, this screening assessment would benefit trauma survivors, given the extensive range of adverse health outcomes resulting from prolonged, untreated PTSD.

De Oliveira et al. (2021) and Papachristopoulos et al. (2023) both presented a significant gap in psychiatric education and internships that may lead to inadequate exploration of PTSD and trauma by psychiatrists in training. Inadequate training at the master's degree level regarding trauma assessment is another factor why emerging clinicians do not prioritize trauma and PTSD in their internships. Incorporating theoretical modules on trauma and trauma-related disorders in residencies is recommended, especially for countries impacted by violence. All practicing mental health

clinicians should incorporate the most recent literature, primarily if published after the last update to manuals like the DSM, which is revised every 3 to 5 years.

The Examination of Linguistics and the Craft of Communication Concerning Trauma

Previous sections of the paper have emphasized the importance of language and tailored communication in uncovering PTSD and trauma, making symbolic interactionism a critical perspective for this study. Recent studies have indicated that specific demographics are notably vulnerable to PTSD or trauma, particularly when linguistic obstacles and communication challenges with healthcare providers hinder the personalized articulation of experiences. Drozdek and Moyene-Jansen (2020) discovered that the communication difficulties faced by immigrants and refugees seeking trauma treatment significantly contribute to long-term psychopathological outcomes. Similarly, Zeina et al. (2024) established a correlation between prevalent sleep disorders and PTSD in populations such as refugees, the homeless, and incarcerated individuals who also contend with substance use disorders by utilizing narrative opportunities during the assessment process. Women experiencing homelessness were often found to have a history of childhood trauma, with visits for sleep aversion linked to these experiences; however, they were unable to express their feelings in a way that met PTSD criteria. Auxemery (2021) noted that PTSD is a Major Neurocognitive Disorder (MND) that can look similar to Behavioral and Psychological Symptoms of Dementia (BPSD) and can be misinterpreted by the communications of the patient. Bruneau's mixed-method study revealed that late-life PTSD resurgence may superficially resemble MND or BPSD, with

flashbacks being misinterpreted as hallucinations, hypervigilance as paranoia, night terrors as sleep disturbances, and hyperactivity as agitation or aggression. Unrecognized PTSD earlier in life significantly heightens the risk of dementia. Misdiagnosing BPSD adversely affects the quality of life, increases hospital admissions, prompts premature institutionalization, necessitates excessive physical and pharmacological restraints, and escalates healthcare expenses. Accurate assessment and diagnosis with culturally appropriate language can lead to appropriate medical treatments and interventions, altering medication and treatment strategies.

Identifying trauma and PTSD necessitates the careful selection of words, individuals, and timing. In a study by Carson (2021) involving young adults aged 18 to 29, it was observed that discussing experiences of sexual victimization led to a reduction in symptoms of trauma and PTSD, provided that such discussions were unsolicited. Conversely, solicited disclosures resulted in 100% of women in the study meeting the criteria for PTSD. These results suggest a critical need for society, healthcare professionals, education institutions, and families to receive psychoeducation on appropriate responses following an unsolicited disclosure of sexual assault. Although this study focused on younger women, compared to my current study, its conclusions offer valuable insights into the significance of communication and the issue of undiagnosed trauma.

Treatment

While existing literature, such as the studies by Etingen et al. (2020) and Saint Arnault and Sinko (2019), outlined the process of receiving treatment for PTSD in

women, there is scant information regarding the post-treatment phase for individuals with prolonged, undiagnosed PTSD. The qualitative research by Etingen et al. underscored that there is no uniform solution in the current PTSD treatment options. Even widely accepted methodologies such as Eye Movement Desensitization and Reprocessing (EMDR) and Cognitive Behavioral Therapy for PTSD (CBT-PTSD) are not universally effective. Their findings highlight the importance of tailoring treatment plans to the individual, considering personal preferences and specific requirements. Due to prevalent issues like misdiagnosis, untreated conditions, and nondisclosure associated with PTSD, much of the contemporary research emphasizes holistic approaches that complement traditional therapy, aiding in the restoration of mind-body connections and healing of the brain's synaptic regions. Activities like nature outings (Barrett & Currin, 2024), equine-assisted therapy (Rosing et al., 2022), yoga (Ong, 2021), music, and physical exercise (Pebole, 2019) offer more personalized treatment strategies for alleviating PTSD symptoms.

In addition to the literature mentioned above, Giesbrecht et al. (2022) found that when it comes to diverse and Indigenous cultures, it is apparent that the incorporation of cultural teachings and art-based projects, especially for untreated trauma from intimate personal violence, helps to heal and promote post-traumatic growth. The growth is not done by focusing on trauma but on cultural teachings, art-based and self-care activities, and peer support to build resilience, increase connectedness, and improve overall well-being. Interventions that are trauma- and violence-informed, culturally informed, and

strength-based were used, and the participants showed overall improvement compared to initial scores at the 1-year follow-up.

According to Halstead et al. (2021), Ketamine-assisted therapy provides relief for individuals who do not respond well to conventional PTSD treatments by enhancing brain structural plasticity. Known as a dissociative anesthetic, Ketamine is classified as an arylcyclohexylamine (Kolp et al., 2014). This class of compounds primarily affects glutamate, a neurotransmitter associated with PTSD and depression, by inhibiting the N-methyl-D-aspartate (NMDA) receptor, which glutamate typically activates. When administered at doses that induce an altered state of consciousness, Ketamine reduces negative affect, promotes openness to new perspectives, and facilitates comprehensive self-exploration. These symptoms enhance the efficacy of psychotherapy both during and after its use, proving it to be an effective tool for recovery from depression and trauma.

Research by Shafia et al. (2023) suggested that fluoxetine combined with exercise may be more effective for women than men in treating PTSD symptoms. Given that most existing PTSD research predominantly focuses on males, there is a critical need for studies centered on females to better understand what effectively alleviates PTSD symptoms and aids in restoring prefrontal brain-derived neurotrophic factors (BDNF) in female populations. From a feminist trauma perspective, empowering clients with knowledge can foster self-awareness, assertiveness, and an understanding of realistic, social, and cultural limitations, acknowledging that these are part of the healing process and that nothing is inherently flawed within them. Specific recommendations for PTSD following childbirth include trauma-focused psychotherapy, CBT, and EMDR. Becker-

Sadzio (2020) demonstrated that Dialectical Behavior Therapy for PTSD (DBT-PTSD) and exposure therapy are effective treatments that can be administered during pregnancy, as many medications are contraindicated. These interventions help mitigate PTSD symptoms associated with low birth weight in the third trimester while enhancing the mother-child bonding experience, which is often compromised by the distress caused by PTSD symptoms.

However, these strategies often neglect to address concerns commonly reported by women, such as identity disruption, feelings of disempowerment, mistrust of medical professionals, and social isolation—critical issues that a feminist trauma approach aims to tackle (Krzemieniecki, 2022). Additionally, exercise is recognized for its ability to alleviate depressive symptoms in both diagnosed and undiagnosed PTSD cases. It serves as a potent intervention for enhancing mood and preventing the worsening of depressive symptoms.

Owen (2024) found that due to the stigma and lack of mental health resources globally, the need for online support for PTSD is becoming an important topic. The National Center for PTSD (NCPTSD) Model for Digital Mental Health has been developed to guide digital mental health technologies. An evidence-based, pragmatic approach can be adapted to meet the needs of different populations and environments. Especially for those military veterans who are aware they have PTSD but are resistant to seeking treatment due to the stigma, lack of knowledge about treatment options, and feelings of isolation. Hamblen et al. (2023) found that an online program, “Considering PTSD Treatment," which was adapted from the National Center for PTSD’s AboutFace

website, showed the potential to create a supportive environment that encourages treatment-seeking behavior. Cloitre et al. (2024) found that STAIR, a virtual present-centered therapy, helped women who did not want to participate in trauma-focused therapy, who were survivors of sexual assault. The results showed positive results in enhancing social support and interpersonal skills and improving emotion regulation.

While online tools are showing promise in helping people manage their PTSD symptoms, Ellis et al. (2022) found that PTSD Coach Online, initially created for those in the military, also worked well for women living with PTSD in Egypt. One of the most significant limitations is the lack of human connection and interaction. Technology-based interventions are shown to help support those who cannot find the healthcare treatment they need. However, to find these options, one must be aware of what is causing the distress, which can be addressed with proper assessment and treatment.

Post Traumatic Growth After Treatment for Untreated Trauma

Current literature has largely explored various themes of post-traumatic growth (PTG) among women who have recovered from PTSD or trauma. However, there is a scarcity of studies focusing on whether growth occurs in women who have experienced prolonged undiagnosed trauma and subsequently achieve PTG after treatment. A notable mixed-methods study by Denise and Sinko (2019) addressed the healing trajectories of women who survived childhood sexual abuse (CSA) and unwanted sexual encounters (USE) during young adulthood. This study also examined how the sociocultural environment tends to tolerate, excuse, and normalize sexual violence, thereby diminishing the severity of these acts and influencing the survivors' perspectives.

Although PTG is possible for these women, further research is imperative, highlighting the need for empowering interventions that foster engagement in psychosocial development. A qualitative study by Ellis and Wieling (2024) investigated PTG in LGBTQ women and nonbinary individuals aged 21-55, identifying three significant themes: healing through interpersonal connection, self and relationship learning, and political dimensions of healing. Despite not addressing untreated trauma directly, this study provides valuable insights into healing processes facilitated by interpersonal engagement. It highlights trauma-informed methods to address relational pain in a population often affected by early societal and environmental trauma. Participants conveyed that sharing, connecting, and assisting others with their trauma facilitated their healing, which aligns with Edwards et al.'s (2021) findings concerning women in sober living homes who discovered purpose in aiding research to help other women overcome trauma. Similarly, Baenziger et al. (2023) observed comparable findings among parents of childhood cancer survivors who experienced PTG through connections with other parents sharing similar experiences, alongside spiritual transformation and a heightened appreciation for life.

The results of this particular study significantly contributed to the currently limited body of literature focusing on examining the effects of treatment specifically for women who have experienced undiagnosed PTSD and unaddressed trauma. These findings can play a crucial role in aiding in the advocacy for essential social stigma and systemic transformations in education and healthcare, aiming to avert the recurrence of such distressing occurrences in the future.

Summary and Conclusions

The issue of untreated PTSD or trauma is a crucial topic that warrants further research to explore preventive measures from various perspectives. Current literature has revealed the substantial number of women who may not receive treatment, the adverse consequences, and the worldwide ramifications. However, it has not adequately addressed the processes women go through who endure trauma and eventually receive treatment (Agha et al., 2024). The journey women undertake to access treatment, along with the mental, physical, and financial challenges and barriers of potential misdiagnosis within the healthcare system and society, remains unexamined. Concerns related to mental health before and after childbirth (Krzemieniecki, 2022; Patterson et al., 2019; Pilay et al., 2022), generational trauma (Agha et al., 2024; Bartal, 2023; Beck, 2023; Matoba, 2023), cultural diversity (Cook & Shear, 2001; Halstead, 2021; Jegaral, 2023); and within the military (Detert et al., 2019; Jiang et al., 2021; Kehle-Forbes et al., 2022; Martin et al., 2021; Peters, 2021) are some of the contexts in which significant portions of these populations have been analyzed, providing a foundation for understanding the effects of untreated trauma. However, these studies offer limited insight into how this journey impacted women and their experiences following treatment and healing.

Research has indicated that neglected trauma can adversely affect the lives of women and those within their environment (Ataria & Horovitz, 2021; Spytska, 2023). Barriers within the healthcare system, societal norms, and personal biases hinder these women from pursuing treatment or cause them to seek assistance but halt the process due to their experiences and self-perceptions (Boyer et al., 2022). Consequently,

comprehensive studies that delve into individual narratives may increase awareness and understanding of these women's experiences (Denise & Sinko, 2019), thereby prompting reforms in the current healthcare practices and educational initiatives about trauma and PTSD on a global scale (De Oliveira et al., 2021; Papachristopoulos et al., 2023). Untreated trauma or PTSD is a global issue. This study aimed to bolster support for women who have suffered prolonged periods of untreated trauma, grappling with feelings of defeat, hopelessness, and despair while endeavoring to find meaning in their lives with limited assistance.

Chapter 3: Research Method

Introduction

The purpose of this qualitative descriptive study was to examine the processes of middle-aged women aged 40-60 who have lived with prolonged undiagnosed or misdiagnosed PTSD, then analyze the effects of appropriate treatment on their lives to increase awareness and integrated trauma-informed care in strategies for women. In Chapter 3, I discuss the research design and rationale for its selection, the role of the researcher, the methodology, the participant selection logic, and the instrumentation used in data collection. Finally, I discuss the trustworthiness of this study and the potential ethical issues encountered.

Research Design and Rationale

I aimed to listen to and analyze the personal narratives of middle-aged women who have endured undiagnosed PTSD or trauma to find out the processes of finally receiving treatment and the impact it had on their lives.

The following RQs have been prepared for this study:

RQ1: How do women who had prolonged undiagnosed PTSD experience the treatment process?

RQ2: How did treatment after prolonged undiagnosed PTSD influence their lives?

Living with undiagnosed trauma has detrimental effects on women physically, emotionally, socially, cognitively, and financially across the globe (Barrett & Currin, 2024). Rich, substantial, first-hand data from stories gathered is required to understand

these women's processes better. Intensive interviewing was used to address grounded theory coding.

Role of the Researcher

Charmaz (2014) claimed that a constructivist approach involves incorporating the ideas and narratives of participants, recognizing that the researcher inherently shapes the interpretation generated. The researcher consciously acknowledges their biases and preconceived notions concerning the subject matter and uses this personal insight to form a distinctive connection with the research, differing from that of another researcher. The synthesis of the researcher's experiences with the participants' stories forms the foundation of the theory, and one is indispensable without the other. To adeptly navigate the methodological landscape with critical insight and intellectual humility, the qualitative researcher must maintain transparency throughout the research process, enabling the reader to evaluate its potential for replication (Cena et al., 2024). My perspective as a woman who endured undiagnosed PTSD for years before finally receiving treatment provides me with a personal connection to the participants, potentially influencing the interpretation of the data. Provided that I, as the researcher, remained aware throughout the study, maintained an open and inquisitive mindset, and adhered to the four quality criteria of CGT: credibility, originality, resonance, and usefulness (see Cena et al., 2024), this study yielded an abstract comprehension of the phenomenon.

To effectively mitigate or eliminate potential ethical issues associated with the research, I took comprehensive steps to ensure the participants were not known to me

prior to the study, nor would their identities be attached to the research through proper confidentiality processes, and they would remain anonymous. Participants currently employed within my existing workplace were excluded from the study to prevent conflicts of interest. Recognizing the study's highly sensitive nature, only individuals who have completed treatment for trauma or PTSD would be considered suitable candidates for participation. Participants in the study received, via email, detailed contact information for complimentary counseling services, which were available before, during, and after the interview process if any additional emotional distress arose from discussing their experiences. To systematically address potential biases, a methodological journal was diligently maintained for reflexivity, thereby preventing preconceived interpretations of the collected data (see Charmaz, 2014).

Methodology

Participant Selection Logic

Constructivist grounded theorists often embark on their research journeys by planning to interview individuals whose experiences can illuminate the subject under investigation (Charmaz, 2014). In this study, the focus was on selecting women aged 40 to 60 who have endured prolonged PTSD or trauma for at least 1 year without a diagnosis and subsequently received treatment. The sampling approach was three-pronged: utilizing social media platforms (Facebook, Instagram, LinkedIn, and Twitter), employing purposeful sampling as recommended by Ravitch and Carl (2021), which involves colleagues in the field who suggested potential participants; and implemented snowball sampling, where existing participants referred others known to them (Ravitch & Carl,

2021). Announcements included a brief overview of the research study and provided contact details via direct message, email, or phone. Participants were not previously acquainted with the researcher and could be referrals from family members, professional peers, other participants, or unknown individuals. Prospective participants were required to self-report enduring undiagnosed PTSD and trauma (Liu et al., 2024; Mak & Wieling, 2024; Margiotta et al., 2022) who have undergone some form of counseling or treatment to address PTSD and trauma symptoms (Agha et al., 2024; Jegari et al., 2023).

In theoretical sampling, conducting multiple interviews and observations is essential to substantiate the final categories identified from the data. Although the fundamental categories cannot be predetermined at the onset of a constructivist-grounded study, possible categories can be drawn from existing literature (Charmaz, 2014). Ideally, the sample size ranges from six to twelve participants. However, theoretical sampling involves defining relevant properties and refining the categories, reaching theoretical saturation when further data comparisons reveal no new properties. These saturation variations mean the sample size can vary based on data analysis (Charmaz & Thornberg, 2021).

Instrumentation

The tools employed in this research adhere closely to the principles of CGT, which guided the methodology and informed the analytical framework. I, along with my worldview and experiences, introduced a distinctive perspective to the study, functioning as a critical instrument in formulating questions, observing phenomena, and engaging in the detailed analysis and discovery of emerging data patterns and themes (see Charmaz,

2014). The semistructured interview question guide (see Appendix C) was a key tool to ensure a balance of flexibility and consistency throughout the study. The interview questions aligned with the study's purpose and RQ and drew on the constructs of the selected symbolic interactionism conceptual framework (Exell, 2019). To obtain rich and in-depth data from the narratives, the questions in the interview guide were open-ended and created with mindfulness and sensitivity to cultural histories, vocabulary, ways of communication, and linguistic challenges that are sometimes connected to PTSD and trauma (Auxemery, 2021; Carson, 2021; Drozdek & Moyene-Jansen, 2020). Nevertheless, the inherently open-ended nature of the intensive interviews allows researchers to explore unforeseen areas of interest and introduce additional questions not initially included in the predetermined interview guide.

Charmaz & Thornberg (2021) and Charmaz (2014) provide a comprehensive elaboration on the process of open, axial, and theoretical coding, which are critical for categorizing data, alongside techniques like constant comparison, memo writing, theoretical sampling, logic diagrams, conditional/consequential matrices, and integrative diagramming. These are identified as integral components of the analytical process of CGT, which were systematically employed throughout this study to ensure rigor, credibility, and overall quality.

Procedures for Recruitment, Participation, and Data Collection

In this qualitative research study, participant recruitment was performed by implementing purposeful and snowball sampling strategies. These sampling methods were utilized to identify and select individuals who possessed direct and relevant

experiences pertinent to the RQ posed in this study (Charmaz, 2014): What is the process experienced by women aged 40 to 60 who have lived with untreated PTSD or trauma for more than a year and how has eventually received treatment influenced their lives?

Recruitment strategies involved obtaining consent from seven women who had experienced undiagnosed trauma or PTSD, then received treatment, and examining how the process impacted their lives. Study announcements were posted on social media platforms and shared with clinicians in the field. Upon initial contact with a prospective participant, a formal email detailing consent, the purpose of the interview, procedures, its voluntary nature, potential risks, availability of counseling support if necessary, benefits of participation, privacy measures, and contact information for further inquiries was sent.

In-depth, semistructured interviews employing an interview guide, along with interview transcription, memo writing, and reflexive notes, were the principal methods for data collection. Interviews were scheduled and conducted in person or via the Zoom platform, utilizing its integrated transcription capabilities, following the volunteers' receipt and signing of the Walden IRB consent form. Only voice recordings, with no video footage, were captured, contingent upon the participant’s approval. Zoom’s close-captioned feature enabled the transcription of conversations for subsequent analysis to transcribe the conversation for me to analyze afterward. This recording facilitated my focus on questioning and conducting the interview. I conducted these interviews from my home alone to ensure confidentiality. Each interview was limited to 90 minutes. I checked in before, during, and after the interview, with counseling available in case of

any trauma or distress elicited by the session. I also communicated subsequent steps and expectations.

Data Analysis Plan

The data analytic strategy for this study utilized the principles of CGT as articulated by Charmaz (2014). The procedures for handling commenced with initial grounded theory coding, a critical step that involved delineating the core elements captured within the data. Through the framework of symbolic interactionism, this coding phase presumes that societal constructs precede individual experiences, acknowledging our existence within a tangible environment (Charmaz et al., 2018). Within this paradigm, the narratives obtained from participants yielded insightful, significant, and subjective reflections on how prolonged undiagnosed PTSD or trauma can be effectively mitigated in the future.

Coding entailed categorizing data segments with concise labels that concurrently encapsulate and elucidate each data fragment. Employing word-by-word or line-by-line coding was advantageous during the initial stages, which was subsequently followed by focused and axial coding. Memo-writing and journaling remained integral throughout the data analysis process, serving as a continuous practice that enabled the researcher to pause, concentrate, compare emerging codes, and define their interconnections. Through comprehensive theoretical sampling of the emergent categories, achieving saturation implied that additional data collection was unnecessary. Ultimately, theoretical sorting, diagramming, and integration were undertaken to refine and fortify the relationships among categories, which were repeated as needed (Charmaz, 2014).

Issues of Trustworthiness

CGT research approaches the concept of trustworthiness in a manner that fundamentally differs from other qualitative methodologies, owing to its primary aim of developing new theories rather than merely comparing them to preexisting ones. This distinction becomes apparent because CGT focuses on creating and emerging novel theoretical frameworks. While this section outlines traditional criteria for evaluating qualitative research, it is crucial to emphasize the four primary criteria specific to CGT studies identified by Charmaz (2014): credibility, originality, resonance, and usefulness. Credibility, which aligns closely with conventional methodological requirements, has been addressed in this section. Originality, as articulated by Charmaz and Thornberg (2021), involves research that provides new insights or perspectives on well-recognized issues, thereby indicating the importance and relevance of the analysis conducted. Through the application of resonance, the development of concepts, and the alignment of data collection strategies designed to illuminate participants' narratives and experiences, this study seeks to provide innovative and groundbreaking insights to professionals in the field. Usefulness encompasses enhancing the research participants' comprehension of their everyday experiences, serving as a basis for policy and practice applications, fostering new avenues of research exploration, and exposing widespread processes and practices, as Charmaz and Thornberg (2021) discussed. Existing literature has indicated a global deficiency in proper PTSD and trauma assessment methodologies, alongside insufficient education regarding the importance of informing healthcare professionals and the public about the long-term effects of unaddressed PTSD and trauma. The narratives

obtained in this study could potentially validate or unveil new information, thereby helping refine existing systems and promoting more trauma-informed or healing-centered practices.

Credibility

In the context of grounded theory, Charmaz (2014) defined credibility as rigorously established by gathering ample relevant data, which enables incisive questioning to emerge naturally, engaging in systematic comparisons throughout the research process, and conducting a highly comprehensive analysis. Credibility further involves carefully conducted interviews, paired with the systematic application of grounded theory methods, ensuring that these techniques align clearly with the empirical data and the researcher's perspective and actions (Charmaz, 2017). CGT requires a high degree of reflexivity throughout the research process, requiring researchers to articulate their underlying assumptions, thereby achieving ‘methodological self-consciousness’ to recognize how unacknowledged beliefs may influence the research. This reflexivity requires researchers to be open to critically examining their own identities about the research (Charmaz & Thornberg, 2021). For this study, interviews were conducted with sufficient participants to reach data saturation; comprehensive data analysis was performed through careful observation, reflexive journaling, and peer review was employed systematically to enhance the overall credibility of the research findings.

Transferability

Qualitative research engages with smaller segments of the larger population to deeply explore specific issues, yielding findings particularly relevant to the selected

participants within a defined context (Cena et al., 2024). The methodological approach adopted in this study, which included purposeful and snowball sampling alongside semi-structured, intensive interviews, can be adapted to any population or demographic group as long as it is appropriately tailored to the specific cultural setting. The literature reviewed in this research highlights the issue of undiagnosed trauma as a widespread concern in various contexts (Agha et al., 2024; Barrett & Currin, 2024; Li et al., 2023), and the process of identifying participants to contribute qualitatively to the literature will significantly enhance the study's transferability and validity. Researchers exercise creativity and innovation to investigate diverse populations across different genders and cultures, thereby enriching narratives to advocate for individuals experiencing undiagnosed PTSD and trauma.

Dependability

The application of the CGT process, along with its various analytical tools, significantly reinforced the reliability of this study, as demonstrated by Cena et al. (2024). By thoughtfully employing constructivist strategies, including comprehensive interviewing, detailed theoretical coding, and reflective memo writing during the analysis, the researcher remained acutely aware of potential biases and limitations while critically examining existing ideas and concepts related to the topic of the question. To effectively mitigate the researcher's personal biases, a dedicated committee thoroughly reviewed the methodology, assessed the data, and scrutinized the coding to ensure the ongoing practice of researcher reflexivity is maintained throughout the study.

Confirmability

Qualitative research papers meticulously maintain a comprehensive and detailed account of the data collection and interpretation processes to enhance the confirmability of the findings. Within the research narrative, this audit trail becomes partially evident, including original quotations and other forms of data that directly inform the researcher's interpretations. This transparency allows readers to verify that, given the identical data set, they might have reasonably reached conclusions similar to those drawn by the researcher (Ellis, 2019). A fundamental aspect of confirmability in qualitative research is acknowledging and recognizing the researcher's influence on the research process, a concept known as reflexivity. Reflexive researchers are highly conscientious about how their preconceptions and biases affect the design, execution, and data analysis of the study. The researcher discloses the unique perspective through which they approach the topic, enabling readers to understand the factors influencing the researcher's views and better understand the motivations behind the research (Ellis, 2019).

Ethical Procedures

Approval from Walden University's Internal Review Board (IRB) was secured following the institution's IRB and ethics guidelines (Walden University, 2020, 2021). Once IRB approval was obtained, reference # 05-23-25-1164249, data collection followed those guidelines. Participants were recruited through social media, peers, and referrals based on an invitational announcement. Upon expressing interest, potential participants received an email that included the study invitation, participation criteria, and a Walden IRB-approved consent form. Participants replied with "I consent" and

acknowledged that they met the requirements to participate in the study. The email also contained a crisis hotline number and mental health resources alongside the interview questions to assist in case of any distress resulting from the conversation. During the interview, verbal consent was verified, along with confirmation that participants had completed treatment for previous PTSD or trauma. I adhered to the ACA Code of Ethics, particularly Section G, involving research and confidentiality responsibilities (G.1.b), record maintenance (G.2.i), and impartial result reporting (G.4.a), as per the ACA, 2014.

Names and other identifiable information were removed from all stored material and replaced with pseudonyms. The identifying data were encrypted and stored on a thumb drive locked securely in my desk. Recordings were stored separately in my laptop, protected by a unique password. They will be destroyed once they are no longer needed (after the mandatory 5-year retention period). Current firewalls and additional security measures bolster the laptop's security. I personally handled transcriptions to ensure confidentiality. Pseudonyms were applied before the committee reviewed to maintain confidentiality. All physical documents, such as papers and notes, were digitized and then shredded. Audio recordings and transcription data gathered via the Zoom platform were stored in a password-protected, encrypted cloud drive. After downloading the audio and transcription files to a secure, password-protected storage device on my computer, the files were permanently deleted from the Zoom cloud drive to enhance security. These data collection and storage measures are designed to safeguard participants' confidentiality effectively.

Summary

This qualitative descriptive study aimed to investigate the process of women aged 40-60 who have lived with undiagnosed or misdiagnosed PTSD or trauma. The focus of this research was on understanding the transformative impact that comes with receiving appropriate treatment for PTSD experienced by the participants. The study employed CGT to utilize purposeful and snowball sampling (a primary data collection method) in obtaining participation in intensive interviews to gather in-depth insights. The study strongly emphasized maintaining participants' confidentiality and upholding ethical standards throughout the research process to ensure ethical rigor. Additionally, the validity of the study's findings was supported by comprehensive data analysis and a commitment to methodological transparency in reporting the research procedures and results.

Chapter 4: Results

Introduction

This qualitative CGT research focused on examining women who had endured prolonged, untreated PTSD before finally receiving therapeutic intervention. The study aimed to investigate the processes of such treatment and how it influenced their lives. To achieve this, I conducted and analyzed in-depth interviews designed to establish a secure and supportive environment, facilitating conversations that delve into the participants' journeys and ideally result in an empowering experience (see Charmaz, 2014). Two central questions guided the research:

RQ1: How do women who have had prolonged, undiagnosed PTSD experience the treatment process?

RQ2: How did treatment after prolonged undiagnosed PTSD influence their lives?

This chapter will present the study's findings, offering comprehensive descriptions of the interview experiences, detailing the data collection and coding procedures, outlining the emergent data and subsequent analysis, and highlighting the deliberate measures taken to establish trustworthiness. Finally, I will present the results and insights that emerged from this investigation.

Setting

Participants were located across various regions in the United States, including Alaska, Florida, Virginia, Tennessee, Texas, and Washington. Each participant selected a confidential environment for a Zoom virtual interview with me, who conducted the interviews from my home alone equipped with headphones and in a private space free

from interruptions. The prevalence and acceptance of virtual interview settings have notably increased after the COVID-19 pandemic. Zoom provides a secure interview platform, featuring closed captioning and video recording capabilities (Gray et al., 2020; Lawrence, 2020). Only the audio of the participants was recorded.

Throughout the interviews, it became evident that the participants had engaged in significant therapeutic work and personal healing related to their trauma. Emotional distress was minimal, characterized by the occasional deep breath but rarely resulting in tears or signs of significant turmoil. The emotions conveyed during the discussions primarily centered on the inadequate support they received when seeking help, rather than the trauma itself. Many participants expressed their frustration with the healthcare system, detailing their experiences, which could be perceived as an additional source of trauma. Nevertheless, the depth and richness of the narratives provided valuable insights and did not adversely affect the study's outcomes.

Demographics

The study's participants were selected through purposeful sampling and included individuals who had experienced prolonged undiagnosed trauma or PTSD prior to receiving treatment. The aim was to explore the process and analyze how treatment has influenced their lives. Participants were drawn from various states across the United States and ranged in age from 40 to 60 years. The participants included an unbalanced representation of diverse backgrounds; three women with military experience, one woman of color, all of whom had undergone treatment for their respective traumas (see Table 1).

Table 1

Participant Demographics

Number	Alias	Age	Race	Country
1	Flora	43	White	United States
2	Wanda	46	White	United States
3	Alice	48	White	United States
4	Violet	46	White	United States
5	Karen	58	White	United States
6	Iris	40	White	United States
7	Tonya	56	African American	United States

Data Collection

Recruitment and data collection began in June 2025 and concluded in July 2025. All seven participants who responded to the study invitations met the established inclusion criteria, provided signed consent, and scheduled appointments for their interviews via email or text. Each participant engaged in a video interview conducted through the Zoom video conferencing platform. Data were collected, audio-recorded, and transcribed utilizing Zoom, with the automatic transcription feature being saved directly to my personal computer. To safeguard participants' confidentiality, the video recording function in Zoom was disabled, ensuring that only audio data was captured. A semistructured interview guide (see Appendix C), a primary data collection tool, was employed to facilitate in-depth interviews. Additional data sources consisted of one

follow-up telephone call to clarify any concepts or patterns that emerged from the data, as necessary. Reflexive notes, memos, nonverbal cues, and visual observations from participants during the interviews were documented as part of the data sources, organized within the interview guide, and utilized in the final data analysis.

Interviews

I conducted in-depth interviews using the Zoom platform from the privacy of my home office. I encouraged participants to choose a time and location for the interview to ensure a quiet and private environment. Interviews were scheduled at the participants' convenience. I logged into each interview session 5 minutes before admitting the participant. Each interview commenced with an introduction, which included the study's objectives, my obligation to report any instances of current abuse, and assurances of confidentiality. Participants were reminded that they could withdraw from the session at any time and that counseling would be available should they experience any distress during the interview. All interviews exceeded 60 minutes, with most extending to the 90-minute limit. I remained present with each participant until they indicated their readiness to conclude the call. No follow-up phone calls were necessary.

I assigned aliases to each individual to safeguard participant identities and uphold confidentiality. Throughout the data collection process, all participants managed their emotions effectively; only two exhibited minimal emotional responses related to their interactions with healthcare, government, and professional systems following the traumatic event, rather than the trauma itself. Participants conveyed that their

involvement in the interview proved to be more empowering and therapeutic than triggering, and none requested counseling or additional support following the session.

Reflexive Journaling

To ensure high rigor and trustworthiness in my research, I diligently maintained reflexive notes throughout the interviewing process and continued to do so throughout the coding process. As I revisited the narratives shared by the participants, I took the time to thoroughly document my emotions, thoughts, and viewpoints regarding the data that emerged from the interviews. Many of the responses provided by the participants and their associated emotional experiences resonated deeply with my personal feelings and reflections. While managing my emotions was relatively straightforward during the interview process, I discovered that these emotions became increasingly complex and challenging to handle as I began to delve deeper into the data presented. As patterns began to emerge from the responses, revealing a comprehensive and intricate picture of loss and pain experienced by the participants, prioritizing self-care became an essential aspect of my research process. Journaling, a part of the research process, also emerged as an integral and vital component of a self-awareness "check-in," allowing me to navigate my emotions and biases effectively.

Data Analysis

Intensive semistructured interviews were utilized to gather data, which I analyzed through a symbolic interactionism lens. Symbolic interactionism is the major theoretical perspective associated with CGT (Charmaz, 2014). Seven interviews had been conducted when data started repeating and saturation was met. The seven interviews were

transcribed onto their Excel spreadsheet page, labeled with their state or where they are from, and later changed to aliases. The columns were labeled interview statement, initial/open codes, focused coding, axial codes, and social interactionism lens. First, the transcripts were read through the initial or open coding phase, which focused on the actions and feelings captured in the statements. This phase is important to ensure the data fits into the empirical framework to clarify the participants' experience and relevance between relationships between the processes and structures utilized (Charmaz, 2014). Next, focused coding was conducted on the initial codes by reviewing and comparing the data showing the intersections between responses. Focused coding uncovers the most significant or frequent codes emerging from the data. Then, all seven individual focused codings were placed on color-coated Post-it notes. Next, they were combined to create categories (Appendix C) and then transferred to 20 large Post-it note easel sheets of paper to see the data together but separately, according to person and question. The initial categories were then created and written on each paper easel corresponding to the question and the data collected from the participants (Appendix C). Next, axial coding was conducted by reviewing the initial categories through a social interactionism lens and writing each phrase on a small slip of paper (Appendix C). Then, the slips of paper were sorted into different groups and patterns until the data emerged into global categories, categories, and subcategories for both RQs. The data were split into two categories. One set of data fell under how do women who have had prolonged undiagnosed PTSD experience the treatment process, and the second set of data fell under how did treatment after prolonged undiagnosed PTSD influence their lives (Appendix C).

Discrepancies

Only one case emerged as somewhat distinct, but it was not divergent enough to warrant exclusion from the study. Within the case of Iris, two notable discrepancies presented opportunities for a more in-depth examination of the incongruity process (see Patton, 2015). I identified two data points that varied within the narratives during my data analysis. Six out of the seven participants reported repeatedly reaching out to healthcare professionals or counselors over several years in pursuit of an accurate diagnosis; in contrast, Iris consulted a single friend after exiting an abusive relationship and received a referral that effectively met her needs. Iris recounted,

> Yeah, I had a friend of mine actually recommend somebody, she's like, I've talked with her, she has done a lot to help me work through trauma in my life. I really think it could be beneficial. Just have a chat with her. If you don't click, you can look for somebody else. I think she's great. She and I have really similar personalities, so she is like, I think you would really get along with her well.

However, it is noteworthy that Iris remained in the detrimental relationship for four years, attempting to resolve it without seeking assistance from a counselor or therapist. It was not until she moved back to the United States from Ireland and began therapy that she recognized her choice of partner likely mirrored the dynamics she experienced with her mother during childhood. The second data point that differed from the others was that Iris had not received any prior diagnoses before being identified with PTSD. Despite these discrepancies, they did not significantly influence the overall data;

the remaining data points were consistent with those of the other participants and were pertinent to the study.

Evidence of Trustworthiness

Credibility

Credibility in research is established by collecting sufficient relevant data, which naturally fosters incisive questioning, engaging in systematic comparisons throughout the research process, and undertaking a thorough analysis (Charmaz, 2014). Accordingly, seven participants were interviewed to achieve data saturation. Additionally, participant feedback was encouraged during the interview, and they could be flexible with their answers as their journey allowed. Moreover, a comprehensive data analysis, meticulous observation, reflexive journaling, and peer review were systematically implemented to enhance the overall credibility of the research findings (Charmaz & Thornberg, 2021).

Transferability

Researchers enhance transferability when examining smaller segments of the broader population, producing findings especially pertinent to the selected participants within a specific context (Cena et al., 2024). The methodological approach employed in this study, which incorporated purposeful and snowball sampling along with semistructured, in-depth interviews, can be adapted for any demographic or population group, provided it is suitably modified for the cultural context (by tailoring the interview questions). The literature reviewed in this research underscores the prevalence of undiagnosed trauma as a significant issue across different contexts (Agha et al., 2024; Barrett & Currin, 2024; Li et al., 2023). The process of identifying participants to

contribute qualitatively to the literature will substantially enhance the study's transferability and credibility. I applied creativity and innovation in exploring diverse populations encompassing various genders and cultural backgrounds to enrich the narratives and advocate for individuals grappling with undiagnosed PTSD and trauma. While the variation yielded beneficial insights in certain aspects, this will be addressed in the limitations section.

Dependability

As a trauma survivor, researcher, and interviewer, I approached the data with a constructivist lens, implementing strategies such as in-depth interviewing, meticulous theoretical coding, and reflective memo writing to enhance reflexivity during the analysis. I maintained a heightened awareness of potential biases and limitations as I critically explored preexisting concepts and ideas pertinent to the RQ. To effectively address the potential influence of personal bias, a dedicated committee member conducted an extensive review of the methodology, evaluated the data, and scrutinized the coding process, ensuring that reflexivity remained a core practice throughout the study. However, as noted by Charmaz (2014), the researcher is integral to the CGT process, suggesting that some aspects of the researcher's perspective may naturally integrate with those of the participants in the data. Additionally, I engaged with various peers and professors during my coursework to discuss the RQs.

Implementing the CGT framework, along with its diverse analytical tools, considerably enhances the reliability of this study, as illustrated by Cena et al. (2024). By employing these constructivist strategies, including in-depth interviewing, meticulous

theoretical coding, and reflective memo writing, I remained acutely conscious of potential biases and limitations while rigorously examining existing ideas and concepts relevant to the RQ. A dedicated committee also thoroughly reviewed the methodology, data, and coding processes to ensure that reflexive practice was sustained throughout the study.

Confirmability

Confirmability serves as the qualitative equivalent of objectivity. It is essential to employ researcher reflexivity throughout the entire research process. From methodology and data collection procedures to personal reflections, I communicated with my dissertation committee to ensure proper alignment, participant selection, the formulation of interview questions, and analysis. This was conducted with a conscious awareness of my biases through reflexive journaling and peer support to enhance confirmability.

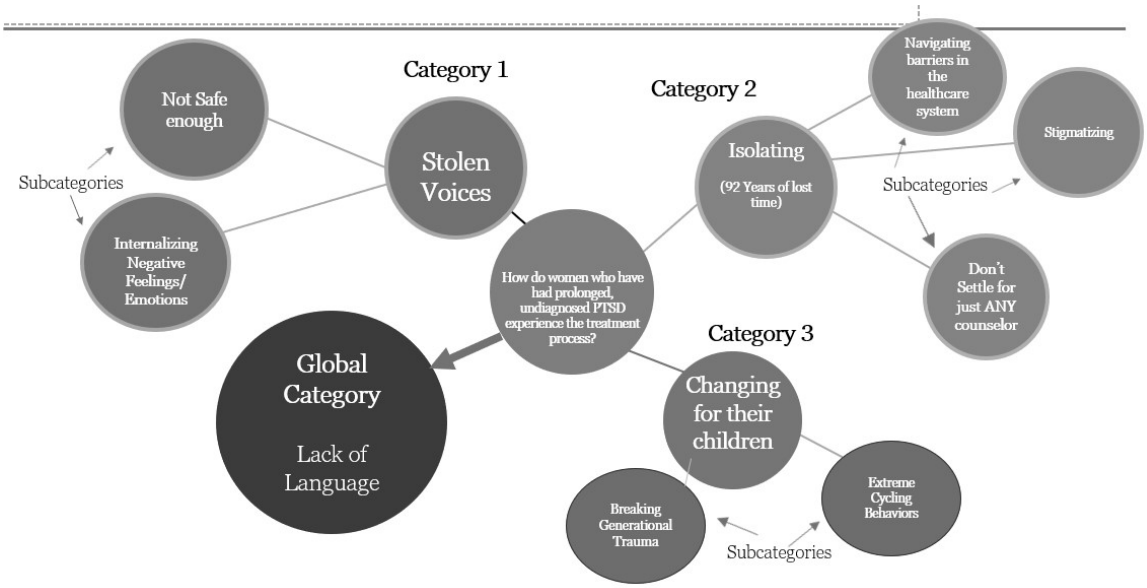
Results

As a researcher, I meticulously examined each narrative and conducted multiple analytic iterations through the individual data sets. Following this thorough analysis, I compared the findings from the seven narratives to identify patterns and common concepts across the data. After several cycles utilizing diverse methods, several categories emerged, categorizing the data according to the two primary RQs (Appendix C). The data about the process of and leading up to the PTSD diagnosis, or "Before PTSD Diagnosis" for RQ1 (see Figure 1), revealed one global category alongside three distinct categories, each with its respective subcategories. Conversely, the data associated with how the treatment influenced their lives or "After Diagnosis for PTSD" for RQ2 (see

Figure 2) also uncovered one global category and three additional categories, complete with subcategories, effectively capturing the experiences of these seven survivors and their remarkable journey through an ordeal they neither sought nor could control.

Figure 1

Before: PTSD Diagnosis Global Category/Categories/Subcategories



Global Category – Lack of Language

In the current literature, Auxemery (2021), Bartel et al. (2023), and Moyene-Jansen (2020) examined the critical role of language in the narratives of survivors discussing their past trauma, and this study corroborates those findings. The coding process revealed a notable disparity between the number of words or codes reflecting the journey prior to a PTSD diagnosis (218) (Appendix C) compared to the number used post-diagnosis (383) (see Appendix C). The number of questions posed to participants remained consistent, and they were afforded equal time and space to articulate their feelings and thoughts. Furthermore, there was a discernible shift in tone as participants

recounted their experiences, often resembling a fairy tale being shared with a child. During discussions of the darker aspects of their stories or when confronting intense emotions, participants exhibited more closed body language, with their voices often lowering or adopting defensive, angry tones, and occasionally expressing tears. This unexpected observation adds a new dimension to the existing literature and presents an intriguing area for further exploration. I will discuss the linguistic aspects following the diagnoses in that subsequent section. The following categories and subcategories support this global category.

Category 1 – Stolen Voices

Category 1, about the period prior to PTSD diagnosis, emerged from participants' accounts of the pervasive silence surrounding their experiences of abuse. They described instances in which their abusers, family members, societal structures, and the very systems designed to offer support failed to acknowledge or respond to their attempts at disclosure. This lack of validation instilled a profound sense of fear regarding sharing their traumatic experiences, often leaving them voiceless for years. As a result, many of these women faced enduring mental health challenges, feelings of self-criticism, and difficulties in social interactions during their formative years, spanning from early childhood to adulthood (Al et al., 2021; DeTore et al., 2021; Favaretto et al., 2022). The participants absorbed the message from their surroundings—family, occupational settings, military contexts, or broader societal influences—that their opinions and feelings were insignificant (Charmaz et al., 2018). They recounted experiences in their efforts to seek assistance that continually reinforced this belief. For instance, Karen, one of the

participants who experienced sexual assault by her father as she entered adolescence, made multiple attempts to report the incidents to both the police and her family. Karen shared her experience:

> Yes, I reached out to law enforcement, but because my dad was friends with law enforcement, reached out to family member's on my dad's side, because I thought my aunt and my grandfather loved me, but obviously they loved him more. They were very protective of him, and so I was rebellious, I was a bad kid.

Participant Flora described her experience as a very young child of family sexual abuse as "a very heavy burden and weight to carry as a kid, because he was our livelihood…I kind of just suppressed everything and moved on with life, and then it hit me in my twenties." Then Wanda, who was neglected as a child, then faced sexual assault as a teenager and in the military, along with additional traumas along her journey shared, "My mother was tired of raising kids and being a mom by the time I was born, so there was neglect, I had to figure a lot of things out on my own," and Alice, who was also sexually and physically assaulted as a child shared, "I was raped when I was 15 and it was reported, and then nothing happened. I was ostracized and penalized in my community for saying anything. There is no point in saying anything. Nothing is going to happen."

Then, Virginia, who was in an abusive marriage and was also sexually assaulted in the military, said,

> I was sexually assaulted while in the military and also raped by my then-husband. When I reported it, I was told that there is no such thing as spousal rape. There

> was zero help, and I didn't get it until I made a scene by trying to take my own life, and then I got put in an anger management class instead of some type of victim support.

Ultimately, Tonya, a woman of color who has endured military sexual assault, recounts her experience during a time when she required medical assistance yet felt unable to seek help. Tonya commented,

> I was enlisted, and I was a sergeant. I was the person who did the court martials, the Article 15s, the chapters. I was the clerk, the paralegal, so I had been at the meetings with the First Sergeants and Captains and the chain of command, where they were trying to discredit women and men who had been molested. So, I already knew that I would not be getting help from my chain of command for my military sexual trauma (MST). I would not be getting support, I never said a word, I never said a word.

Many of these individuals experienced their voices silenced due to a lack of belief from their families or the systems established to safeguard them. For some, their developmental stage prevented them from possessing the vocabulary necessary to articulate their experiences, leaving them to grapple with the internal conflicts arising from these traumatic incidents. This often manifests early in their lives, resulting in symptoms such as anxiety, ADHD, depression, suicidal ideation, and defiant, aggressive behaviors. These symptoms are frequently associated with children labeled as "troublesome" within our educational system. In addition to these explanations, two subthemes emerged within the theme of silence: the perception that it is unsafe to

disclose experiences to family, healthcare providers, or societal institutions (which leads to silence) and the complex emotions associated with shame, guilt, hopelessness, loneliness, fear, ostracism, and disbelief (which also leads to silence).

Subcategory 2 – Not Safe Enough. The narratives of the participants revealed a pervasive hesitance to disclose their experiences to various individuals or institutions, including family, friends, healthcare providers, workplaces, military personnel, and societal systems such as law enforcement or foster care. While the reasons for this reluctance vary, they predominantly center around societal perceptions and the stigma surrounding trauma, sexual abuse, PTSD, and domestic violence (DV). The prevailing societal attitudes towards mental health, particularly regarding the pursuit of assistance for PTSD or related trauma, instill fear in individuals who need support. This fear often stems from concerns about social ostracism, the imposition of negative labels, or an internalized sense of weakness. Consequently, these perceptions generate feelings of fear, guilt, and shame associated with the need for help in relation to experiences that occurred through no fault of their own, yet which still lead to negative self-perceptions (Charmaz et al., 2018). As a result, survivors of trauma, including these participants, may choose to suppress their experiences and refrain from seeking assistance or reach out once and never again for how they are treated when they do. For instance, Flora, now in her 40s, continues to feel unsafe in disclosing her childhood sexual assault to her family, as illustrated in her narrative:

> My abuser was my stepdad, and everybody in the world thinks he's the kindest person ever. Oh my God, he's so sweet! He's so nice, blah blah blah. He's a

> gentle giant. My daughter's dad knows. It's always who nobody ever expects. I have not told anybody in my family about it. Well, my sister knows, but nobody else does. This is a conversation I've struggled with my therapist many, many times. There are two sides I have to weigh out. There are the people who should know, and then there are the people looking in from the outside, and are like – why the fudge wouldn't you tell everybody? They don't understand the relationships that I have a larger risk of losing, which would be my mom, and then his 3 kids that I have grown up with since I was three years old, and my sister actually lives near me and we are very close. It's very complicated. Those are my two biggest ones, my mom and my sister. I can't risk losing those relationships.

Wanda's perception of inadequacy in terms of safety invaded her professional environment, prompting her to engage in a pattern of rapidly commencing and subsequently departing from jobs. This cycle was compounded by her experiences of impostor syndrome and her encounters with workplaces that lacked sufficient policies and regulations to ensure a secure atmosphere. Wanda shared her experiences through the following narrative:

> Yeah, very toxic. The girl who was training me told me things like I hadn't earned the right to talk, and all the layers of life up until then, and then my mom, and a new job, and all of this at the same time. So that started catching up on me, and I started crying every day at work, and I would go into a patient's room, just bawling, and I would be, my name's Wanda, I'm going to be your nurse, and I

> can't freaking work like this. Alert, alert, alert. I went to my doctor and told them I signed a residency contract, and I can't get out of work, out of this place, but I only have a month left, and I cannot go back. I cannot work there. So, he just wrote me a mental health leave, and they didn't have to know, and so I didn't have to go back. That set the stage for me as a brand-new nurse, and so it was just, it's my whole body, you're dumb, you're stupid, you don't know anything. Yes! Then I started this pattern. I've been a nurse for 15 years, and I would jump from job to job to job to job, and I've had 21 jobs in 15 year.

All participants recount experiences similar to those of Flora and Wanda, indicating that their self-perception and outlook on the world are marked by a sense of danger (cite social interactionism). This persistent feeling can lead to the reactivation of undiagnosed trauma. As demonstrated by Ataria and Horovitz (2021) and Spytska (2023), prolonged periods of unrecognized PTSD or trauma can adversely affect fundamental processes such as the minimal self, potentially resulting in C-PTSD.

Subcategory 3 – Internalizing Negative Feelings/Emotions. Internalizing negative emotions such as shame, guilt, hopelessness, isolation, fear, ostracism, and disbelief can lead individuals to relinquish their efforts and cease striving for improvement (Ataria & Horovitz, 2021; Plante et al., 2022). These emotions are often associated with mental health issues, including depression, suicidal ideation, and actual suicide (Zhang et al., 2019). The act of completing suicide sometimes occurs when attempts for help are ignored. Here are some examples of the participants' emotions and

feelings as they processed seeking a diagnosis for PTSD. Alice articulated some of her emotional experiences:

> So in that 6-year period, I actually almost died repeatedly. I think at that point, I kind of wanted to die, because I had seen this other way to live, and I wanted to get back to being sober, and I just could not seem to do it…I really almost died. I ended up in the hospital a couple of times, and I have a permanent heart condition from some of the things that I did back then…Survival mode is so isolating…it was like my life ended before it ever began… clearly, this God is a he, and he's negligent, and he doesn't care about me.

Then Violet shared some of her feelings during the process:

> Because this all started way, way, way back, with a suicide attempt back in 2006….and my suicidal ideation was just too much, and my commands are way too toxic…I was already deep into depression because I had to get out of the military, and finding a job and everything else, and I was in postpartum at that time, because I had a retirement baby. So, it's been a massive rollercoaster, this entire journey, and just fighting to be heard as a woman. As a veteran, because we get dismissed all the time anyway, oh, you were a nurse. No, I worked on Apache helicopters… It sucked. It was horrible. I never should have had to go through that. And I should have had the help. When I reached out for it the first time…Not, and it took me over a hundred times. It literally took a suicide attempt before I was even like, ah, fine, we'll help.

Then Karen shared,

> He made me feel it was my fault…I was a bad person. I was disgusting… I was so ashamed of what happened to me. I was so ashamed and so embarrassed and guilty that I couldn't bring myself to talk about it. So I didn't… I couldn't do it… I was suicidal before. I didn't want to live, I just didn't want to be here…hopeless, just feeling hopeless, uncertainty.

Stolen voices emerged as a significant category in the data collected. Throughout each narrative, there were indications of individuals being silenced in various ways by different authorities or systems. Experiences of being silenced, dismissed, sent away, or overlooked were prevalent, sometimes leading to extreme considerations regarding death. While it is understandable that some individuals may not seek assistance due to a lack of awareness or understanding of their need for help, a critical failure occurs within the system when those actively reaching out for support encounter persistent obstacles. This lack of proper initial PTSD assessments is evident across numerous systems nationwide (de Oliveira et al., 2021; Fung et al., 2022; Gagnon-Sanschagrin et al., 2022). Leaving people across the globe facing similar inadequate resolutions for their ongoing undiagnosed trauma, as well as facing challenges in obtaining appropriate diagnoses or treatment for PTSD (Smith et al., 2020).

Category 2 Isolating (92 Years of Lost Time)

The second category addresses the significant time lost by these seven survivors due to their PTSD remaining undiagnosed, a consequence of systemic failures in societal "safety measures" at various stages of their attempts to seek help and relief. On average, they lost 12 years each, with the minimum being 4 years and the maximum extending to

20 years. This duration aligns with the findings of Boyer et al. (2022), indicating that their struggles occurred despite their efforts to seek assistance. Additionally, they experienced feelings of isolation, often perceiving themselves as “crazy” due to the way the healthcare system dismissed their concerns, or disconnected from their own bodies, as they navigated the challenges of daily life while contending with the symptoms of untreated PTSD in an unsupportive societal context.

Here are some of their experiences during the process that made them feel isolated. Tonya shared,

> After I started talking about it. It took a long time for me to actually be able to describe everything that happened in the situation, and the VA pissed me off so bad because I finally filed a claim on top of that. They kept making me repeat it. I know I told that story over and over and over and over. If I went back today and decided I needed an increase in the disability that I'm getting, they would turn around and make me do it all over again…Then I found out that they weren't paying me for the MST portion of it, and they denied that portion. They were willing to do PTSD, but there's an extra something they give you for the military section, and they didn't want to give me that, and I had to go before a judge and tell a judge. I'm just like… I got it! But I mean, I was a wreck that whole year…I think I went through 2 or 3 counselors before I finally got one that I liked… I use the VA. But they gave me a VA therapist who was right there at the clinic, so that part wasn't hard.

Flora shared her process with the system that caused her to wait for years to reach out again:

> There was a point when I was like, Okay, I need to get some help. But I wasn't fully ready for it, and it didn't work, and I didn't have a therapist who was good for me… After a little bit, I just quit because I felt judged. I didn't feel like I was getting anywhere with anything. I just said, This is a waste of time and money and quit going. Now it's time to figure it out. I'm 31 years old, like I'm not. I'm not a kid…The 1st go around, I found her on the Internet. I said, You know, okay, and even still, especially in Anchorage, it was, and still to this day, it's hard to really find what you're looking for, as far as a therapist is concerned, online…Looking back now, I can say that she didn't do a good enough assessment on me in the sense that I was in my mid to early twenties, and drinking at that point had started to become excessive…she has prescribed medications for depression through my GP and I almost killed myself on them, and had a moment of clarity where I just dumped them out, because it very specifically says not to still have drinks on them…Yeah, the second go around (10 years later)…so I found her. My assessment with her was like an hour and a half long, or 2 hours. My 1st appointment with her was very long. I told her the problems that I had with the 1st therapist that I had tried, and she very much took that into account, and never once made me feel the same.

Then Wanda shared her process with the system on her attempt to get help:

That started with me going, and then she gave me some advice on how to basically tell my son we're not brushing our teeth, and they won't fall out, and, like, basically undo every good thing you've done, because of how his brain is working. So we did that, and then I just kept going, and he stopped doing the behaviors that he was doing. And I went to see her on and off for probably 10 years…We did a lot of cognitive behavioral stuff and talking, and black and white thinking, and here's this, and… some suggestions. Yeah, I met with her and then several others, and… one of my counselors told me, I'm kind of jumping all over the place, but right before the trauma bucket exploded. I was getting very frustrated with my… almost adult children…For simple things, my son, who was 18, maybe 16 for putting his dirty dishes in the sink, but not the dishwasher, and I was like, this drives me crazy, this is affecting our relationship, like, I can't even talk to him anymore and instead of her saying, this is such a little thing that you seem very overwhelmed with. So what else is going on in your life? Which, ooh, if we had gone there, it would have been like, here's what we need to correct. Instead, she told me. Your children don't love you, your husband doesn't respect you, you need to kick your kids out of your house…that is a very vulnerable place to be. The professional counselors, psychiatrists, psychologists, and doctors have a lot of influence. Had I been a single mom, not with my husband. I could have been, like, kids, get out of here. You don't love me, my counselor said, and then, just destroyed my relationship with them, so…Originally? Mm-mm. Nope. No assessments for trauma.

All participants have endured significant years of undiagnosed trauma that could have potentially been prevented. They expressed a desire for more education, greater opportunities, and increased access to individuals and resources that provide safe environments for sharing challenging narratives. One of the motivations for their involvement in this research study was to assist other women in finding ways to address these issues more promptly.

Subcategory 1 – Navigating Barriers in the Healthcare Systems. During the process of obtaining treatment for their undiagnosed PTSD, the healthcare system significantly influenced the duration required to achieve an accurate diagnosis. Both civilian and military healthcare systems frequently exhibited dismissive attitudes, instances of gaslighting, and a lack of proper assessments necessary for a comprehensive evaluation of PTSD, often prematurely diagnosing individuals with depression or anxiety instead. While many healthcare professionals demonstrate competence in their roles, a considerable number operate outside of trauma-informed care principles (Cooper et al., 2023; Hatch et al., 2020; Korman et al., 2019; Marafini, 2020). While all but one of the participants were diagnosed with symptoms of PTSD like depression or anxiety before receiving their PTSD diagnosis, here are some of their narratives expressing what the process was like for them. Wanda shared a story right after she had her second child was born:

> I went to a doctor, and he said, Oh, yeah, I think you have depression. You can take an antidepressant for it, but at that time, I guess we didn't know if it was safe or not in pregnancy and breastfeeding. He said, We think it is, but we don't know

> if it is safe for the antidepressant to go through breast milk, or if it didn't go through, I don't even know if we knew at that time. He kind of offered it to me, and I said no. I breastfed my first child. I have to breastfeed my second child, and I'm not going to take some medication that we don't even know about. So, just kind of sucked it up…(then) I had a psychiatric mental health nurse practitioner who just… over and over. Here's Lexapro. Okay, let's try Zoloft. Let's try more Lexapro. Let's try Abilify. I was like, I'm not taking an antipsychotic. Like, the name freaks me out. But also, I know I'm going to gain weight. I'm going to increase all these things, and none of this is helping. My last visit with her was telehealth. And she asked if I was suicidal, and I said yes, and I said, But I'm not going to do anything. I have kids, I can't… I know that would ruin their life. I have reasons for living. Yeah. But… but my reasons for living were… minimal.

Then Violet shared her experience with the healthcare system while she was in the military and after her military career during her journey:

> I only just got diagnosed late last month…Yeah, but it was always for depression and anxiety. I've had counselors suspect that I had PTSD, just given all the trauma that I went through and everything, but it wasn't until recently that I was willing to even seek a diagnosis and open that can of worms…I did get counseling, and I got help in separating from him and divorcing, and then got sent to Germany after that, thankfully, because that got me completely away from him so I could heal, and I continued counseling. They finally diagnosed me with depression. They're just like, oh yeah, it's just situational, you're going through a tough time with a

> divorce…Nope, (no assessments for trauma), and every time I try to bring it up, it's just the divorce. It's okay. We'll get you through this hump, and you'll be fine. I was put on every single SSRI receptor inhibitor, except for Paxil. I metabolize too quickly. I went through them all. The one doc that I had right before I medically retired from the Army was like, No, Paxil has just too many side effects, so we're not going to try that. We're just going to keep you as even as we can, and my suicidal ideation was just too much, and my commands are way too toxic. I didn't medically retire until 2016, so another 10 years…When I finally medically retired, I went to a regular provider, a civilian provider who tried me on generic Tegretol. He's like, you don't have bipolar, but… I'm going to give you this to see if it helps, and it actually… I had to go up to the highest dosage before it started helping, but I was able to work my way back down, and I've been mostly even on it ever since. It's the longest medication I've been on that's mostly worked.

The accounts and analyses presented are comprehensive; however, all participants articulate significant concerns regarding the process and the insufficient manner in which their needs were addressed. This issue seems widespread across various civilian locations and military installations throughout the country, prompting inquiries into whether it is a pervasive occurrence. The troubling narratives corroborate the existence of numerous obstacles within the systems designed to facilitate healing and promote overall well-being, instead of hindering access to effective treatment options.

Subcategory 2 – Don't Settle for Just Any Counselor. Rehabilitation centers, youth homes, military counselors, and private practice counselors were also a part of these participants' journeys to getting answers for their symptoms and issues. The concerns align with the existing literature of counselors working outside of their scope, or just acknowledging specific symptoms, but not the PTSD, Agha (2024), and not completing the proper assessments, Auxemery (2021), to guide treatment. Here are their stories.

Tonya shared some frustrations with one counselor: "I had one that kept saying, when you feel a panic attack coming on, just breathe deeply. Bitch, if I could breathe, it wouldn't be a panic attack. You know, I'm like, if anything, it was frustrating." Then Flora shared one of her experiences:

> And there was a point that I was like, Okay, I need to get some help. But I wasn't fully ready for it, and it didn't work, and I didn't have a therapist who was good for me…After a little bit, I just quit because I felt judged. I didn't feel like I was getting anywhere with anything. I just said, This is a waste of time and money and quit going.

Then Violet shared,

> I tried EMDR and I was re-traumatized, because they wanted the worst memories, and it's just like, why would you want to start there? Yeah, I'm not ready for that…Yeah, our primary care managers for every single unit I've been in have been extremely dismissive and gaslighty to anyone who comes in. I had male soldiers who had to fight just to get their back problems seen as legit, because

> they would literally look at MRIs or x-rays and be like, oh, I don't see anything wrong.

Karen shared her experience of having to go to a children's home and her experience with some of the counselors:

> I was court-ordered to go live in a children's home. I think that my guardian, the director of the children's home. He knew that I had a lot of trauma, and they did have a therapist who would come. But the therapist was more about, these are the rules of the children's home, and if you don't abide by rules, then these are the consequences, and you have to do this, and you have to do that, and it wasn't so much about you know, where's all this anger coming from?

The process to obtain appropriate evaluation and treatment for PTSD or trauma is entrenched with numerous obstacles and challenges within the healthcare system, which is expected to be the source of the necessary assistance for those seeking help. These narratives align with the existing literature regarding misdiagnosis by Bailey and Brown (2020) and Fearon et al. (2024). Out of the seven participants, one received an initial diagnosis of trauma stemming from an incident of domestic violence experienced later in life. This type of trauma is typically more readily identifiable compared to childhood trauma that occurs within a family setting.

Subcategory 3 – Stigmatizing. Cultural and demographic groups within society often impose negative stigma, shame, and fear surrounding the disclosure of trauma, which can exacerbate the challenges faced by individuals in distress (Patel et al., 2022; Saraiya et al., 2021). All seven participants experienced hesitation or a significant delay

before initially seeking assistance. Some chose to wait years before attempting to reach out again, influenced by their failed prior experiences during earlier attempts. Their narratives illustrate the impact of stigmatization on their journey toward receiving treatment. Iris, for instance, faced stigmatization as a woman trapped in an abusive relationship in a foreign country, leaving her without the resources or knowledge necessary to seek help for herself and her daughter. Iris shared,

> He started getting physically violent when I was pregnant. If anything went wrong, he would call me, and he would scream at me…Then he would scream at me about things, and just huff and puff, and he smashed cakes, he threw cakes at me, he threw cookies at me… Then he grabbed my arm a couple of times when he wanted me to stop talking…Yeah, did you have to lay hands on me? I know that other women get it a lot worse, where they're hit and punched. It would literally be easier to live on the street than it would be to live with you any longer.

Fortunately for Iris, she confided in a friend who assisted her in escaping while her partner was at work. However, the absence of education regarding the characteristics of a healthy relationship and the appropriate actions to take in such situations was a significant gap in Iris's experience. Now, let us examine Tonya's journey and the impact of stigma on her experience as a woman of color. Tonya said,

> I mean, in the Black community, therapy was not a thing, and it's definitely not for Black people, no…I think it was not necessarily just the culture, but the socioeconomic atmosphere that I lived in. We were in the projects. My mother is not educated, and then went from the military to

> work in a job that was not much over minimum wage, cooking at a local restaurant. She's a single parent doing the very best that she can. For a while, we were even on welfare or whatever… I think the other thing is, especially in the black community, there is so much work that needs to be done with the stigma that is attached to mental illness. You know, the last thing you want to be called is crazy, and everybody has that crazy person in the family. But what they don't recognize is that you can be mentally ill and not be what people call crazy. You can look completely normal. Yeah… that's what I had to say to a friend of mine the other day. The people who are going around shooting up everything are not the people with their hair all over their heads, walking around outside with one shoe, pushing a grocery basket. I mean, just the education 20 years ago, just the education of knowing that it was okay to go through what I was going through, and that even if someone did judge me, I would survive the judgment."

Then Wanda stated why some traumas seem more acceptable than others to society. Wanda said,

> Right when I was about ready to start nursing school, or maybe it was even my prereqs, my dad died, and that's what I would say was a real trauma, because people recognize that, and people talk about death. People don't talk about rape, or unwanted sexual advances, or things like that, especially when you think it's your fault.

Category 3 Changing for Their Children

Each participant experienced a common catalyst for transformation: the onset of family responsibilities. They expressed a powerful desire to enact change for the benefit of their children, as they were determined to avoid passing on generational trauma rooted in their past experiences, which could ultimately influence their children's identities (Matoba, 2023). The participants recognized the necessity of persistently seeking solutions that would foster healing, not only for their well-being but also for the well-being of their children. Alice said,

> Because I want to continue to heal and grow, because ultimately, I would like to have a positive impact on my children's lives and the lives of other women who survived and lived through that, and share my story with them.

Then Violet shared, “They're almost 12 and 7 now, and it's like, hell no, they are not getting this version of me. I want to be better for them and for me.” Next, Karen said,

> I was an adult, I'd had my first child, and she was almost 2 years old, and I was 22. It was because I was so overprotective of her. I had a wonderful husband who was very loving and supportive, and I didn't trust him to be a good dad.” It got so bad he had to give her a choice, “…you need to get some help and he gave me an ultimatum that I either get help or he was divorcing me and taking my child from me.

Then Iris shared,

> I need to work on myself. I need to be better for my daughter, because I was like, It's just me. That's who she has, and if I'm struggling with my mental health, then it's not going to be good for her.

Finally, Tonya shared,

> I had my own issues that affected my child to this day. I was a pleaser. My child is a pleaser. I'm a control freak, and I micromanage my child to the point that he thinks that what he does isn't good enough.

Despite enduring a series of setbacks within the systems designed to safeguard them, they persisted in their pursuit for assistance. When despondency set in, the awareness of potentially harming their children spurred them to continue seeking an accurate diagnosis and appropriate treatment.

Subcategory 1 – Breaking Generational Trauma. Towards the end of the process of finding the correct diagnosis, the desire for their children to live in a trauma-free environment inspired them to break longstanding familial cycles that had been ingrained, concealed, and normalized as a part of their existence (Agha et al., 2024). The following narratives were shared regarding the experiences prior to diagnoses that significantly influenced their lives and sense of identity, and which they were motivated to change. Alice shared an experience:

> There was once, when I was in junior high, and it was around physical abuse. My father and I had gotten into a physical altercation, and he'd given me a black eye. I had a teacher at school. That interceded and called, OCS, I believe, and I don't remember if I told them the truth about what happened or not. It was the culture,

> and you didn't talk about it, and almost like people on a deeper level, kind of knew what was happening, but we hushed it and shoved it under the rug and didn't talk about it. I didn't… it's… when you don't even understand that it's wrong, or that there is something wrong. Yep, that's just the way it was.

Then Flora shared why she still has not disclosed her trauma to her family due to stigma and the fear that she will lose family relationships. Flora said,

> Yeah, it always turned back to like this was our livelihood growing up, and it was really in part of what I struggled with when I did finally get good therapy, that this was not only my abuser, but this was the man who raised me since I was a kid, because my real dad was military and wasn't around until I was in high school, and by then it was too late in this. In that sense, people don't understand it, and I don't understand it myself sometimes. But it was yes, that was my abuser, but that was also the person who raised me.

Finally, Karen shared,

> From a person who was supposed to protect me. From my father, I ended up in a children's home, being punished. I was the one being punished for somebody else's behaviors. That led me to believe that the system and people… everybody who was supposed to protect me had actually… failed me.

Alice, Flora, and Karen's stories are similar in many ways. They all experienced childhood sexual trauma that negatively affected their childhood, adolescence, teenage years, and early adulthood. All three experienced risky behaviors in different ways,

putting themselves in unsafe situations. All three had significantly low self-esteem and feelings of "ugly", "dirty", and "not having a place on this earth."

Subcategory 2 – Extreme Cycling Behaviors. Before diagnosis, most of the participants experienced many toxic, unhealthy behaviors and patterns that put them in danger and externally reflected how worthless they felt internally. All of the participants showed some symptoms of increased risk for developing further mental health disorders due to the prolonged undiagnosed issues, such as self-critical emotions, disturbances in interpersonal relationships, escalating conflicts, deterioration of psychological resilience, employment of defense mechanisms, and challenges in social and work interactions, to name a few, which aligns with current literature (Al et al., 2021; DeTore et al., 2021; Favaretto et al., 2022).

Here are some of their stories. Flora shared,

> I kind of just suppressed everything and moved on with life, and then hit my early twenties, and it was never really much of a party or drinker, but then I started working at the bars. Then the alcohol started, and, as everyone knows, with alcohol starting, then came out all of these suppressed emotions all of the time…When I reached out the second time, I found my therapist. It was because I moved out of state for a year, went back, and it was like, I just picked right back up where I left off in all of the mess, the drama, then you know, I drink, and the emotions come out…So that's been a long, difficult road to figure out how to navigate that. It was when I noticed that these problems weren't going away, that

> I was in this constant cycle and pattern of doing the exact same things over and over and over and over, that I was like, Okay, now it's time.

While Wanda had many different experiences, I chose the ones she had from work since they were unique to the study. Wanda shared her story of cycling behaviors related to work:

> Then I started this pattern. I've been a nurse for 15 years, and I would jump from job to job to job to job, and I've had 21 jobs in 15 years…But a lot of that was that… belief of something's wrong with me. I just kept switching jobs…I started there in January, and my very first day, I was assaulted physically, punched, grabbed. Two days later, same thing, I think. The whole staff watched this patient who was withdrawing from drugs, and no one knew what to do because she was a kid, so we didn't have treatment for that…That continued on and on and on for multiple shifts, so that was starting in January. March 3rd, there was an autistic boy who was 17, and over 6 feet tall, and nonverbal, he threw me up against the wall, headbutted me, and bit the crap out of my arm."

Then Alice shared her experience of recycling behaviors of getting clean of substances, then relapsing, then starting all over again. Alice stated,

> There was always something very uncomfortable inside me, and just around being me. I went to residential treatment when I was 13 years old for alcohol and for behavior, acting out, and such. I literally became agoraphobic in my 20s. I couldn't leave my house without drinking…I just had a sense of being lost in the world. As I got older, my coping mechanism first was food, and then it became

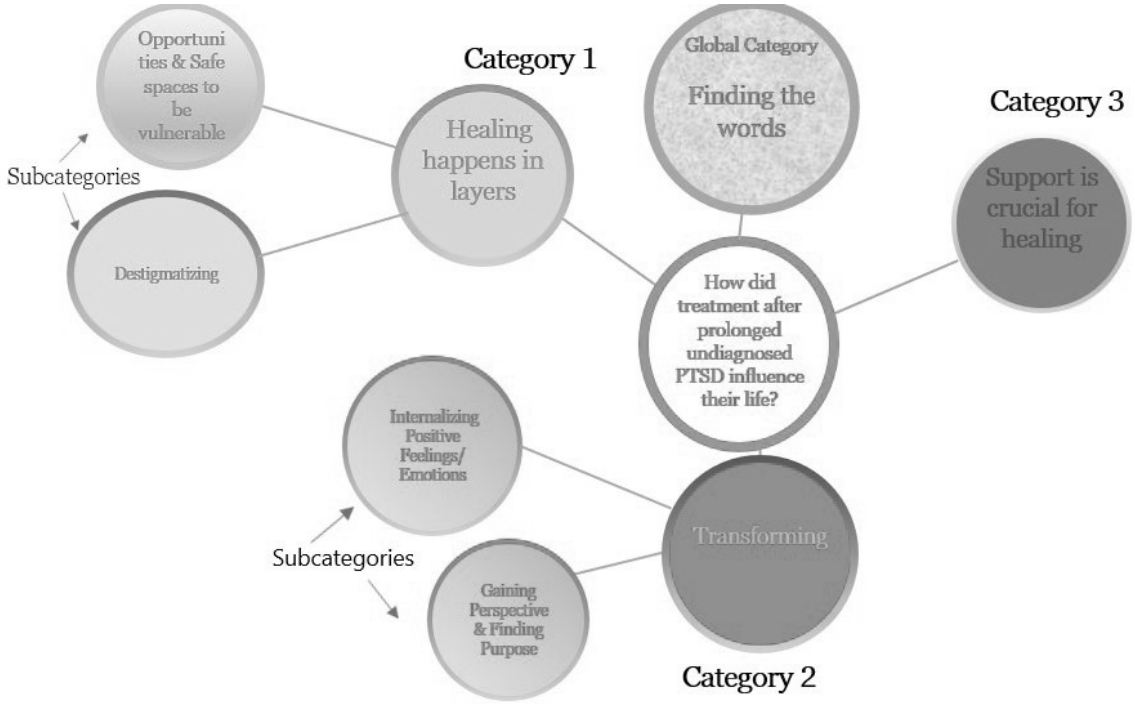
> alcohol, and it manifested as a lot of drinking. What happened to me is that when I was 30, my life had dead-ended. They had put me on prescription ADD meds, which I abused and ended up drinking again. I lost everything. As a result, I ended up getting sober.

The data that emerged from the questions directed to the process of seeking and finally receiving a PTSD diagnosis highlights many challenges women face when trying to communicate and navigate the journey of getting what they need as far as trauma-informed care. These narratives add to the current literature by validating the need for more education on PTSD, more awareness in our communities to normalize speaking about abuse for victims to feel safe, and creating safe spaces for children and young adults not to feel trapped in their own homes when they are in danger, and there seems to be no one to turn to for help. Now we will look at the data that emerged from the research after finding a diagnosis for PTSD and receiving treatment.

Figure 2 represents the data from the questions that represented the interview questions that focused on how the treatment after prolonged undiagnosed PTSD influenced their lives through one global category, three categories, and their subcategories.

Figure 2

After Diagnosis Global Category/Categories/Subcategories



Global Category – Finding the Words

As previously indicated in the other Global category, contemporary literature, including the works of Auxemery (2021), Bartel et al. (2023), and Moyene-Jansen (2020), addressed the absence of adequate language when survivors recount their experiences of past trauma. In contrast, this global category reveals a notable gap in existing literature. The analysis revealed 383 codes (refer to Appendix C) that articulate the effects of treatment on individuals' lives, compared to 218 codes (see Appendix C) indicating their experiences prior to receiving a PTSD diagnosis. This discrepancy underscores the critical importance of obtaining an accurate diagnosis and appropriate treatment in order to fully articulate the narrative of victimization, process the past events

in a safe space, and ultimately enable the transformation from victim to survivor, allowing individuals to thrive. The intense passion, enthusiasm, and desire to assist those who remain in the state they once experienced (before their PTSD diagnosis) are both inspiring and uplifting. Their current positions within their journeys offer hope and direction to others (Carson, 2021) who continue to seek support in the face of seemingly insurmountable challenges. A review of some of their narratives will illuminate how the treatment of previously undiagnosed PTSD has impacted their lives.

Category 1 Healing happens in Layers

The participants recounted their experiences of needing assistance multiple times due to various factors. These included not being fully prepared, the demeanor or attitude of the counselor, the stigma associated with seeking help, or a lack of awareness surrounding their issues. Each individual faced a significant life event that ultimately motivated them to advocate for themselves, enabling them to obtain the necessary support. Throughout this journey, they experienced healing moments, albeit with some setbacks along the way. Each participant developed their own perspective on the healing process following their diagnosis of PTSD.

Flora shared,

> So that's been a long, difficult road to figure out how to navigate that…The first 6 months were hard, like there were many times, I'd go to work. I'd get off work, and I'd go straight over to my appointment, and then I would literally stop at the grocery store and buy cereal and milk and go home, and like nobody text me,

> nobody call me, my boyfriend at the time, there were plenty of times that he's like, Are you really just at your house?
>
> I was releasing everything. Going to counseling twice a week. We just keep trucking through, and then once I started to work through that, I would say, probably halfway through, is where the light bulbs were coming on, and I was, wait a minute, and that was when I really started to change. I was noticing changes within myself, like in my relationship. There were definitely light bulbs coming on. I saw myself changing how I handled other people, how I worried about other people.

Violet shared how traditional therapies and alternative strategies were part of her healing process. Violet said,

> We play Dungeons & Dragons, so we use those kinds of therapy sessions, too. I became a certified therapeutic game master just because bringing tabletop role-playing, energy work, and shadow work all into one thing, and helping people completely get out of their heads and into a fantasy life to help them find new solutions to different things. It's essentially play therapy for adults, but I'm not a licensed therapist; I'm a life coach, so I have to do things a little bit differently, and that's okay, because it's fun. She's like, Have you ever heard of brain spotting? We tried it, and I was able to do my energy work and everything else along with it, and all the cool visuals that I already get when I'm doing meditations, and she was just rolling with it, and it's been transformative. I've had huge leaps and bounds, and with her.

Here are some of Karen's experiences of her healing journey:

> We also did a lot of Carl Rogers-type stuff. I think she was very much a humanistic psychologist, where she believed that we were going to go back and work through the trauma, and one of the things that she told me was that it was going to be unpleasant. And it was going to hurt. Her words were that I was going to have to hurt some more before I could heal. I was going to have to open up and talk about the things I was thinking and feeling, and all this other stuff that was going on. So that I could really become healed, and then once I process it, and once I tell my story enough…She was trauma-focused and repeated the story and told it over and over again until I became desensitized. Yes, she was right, and that's why a lot of people that start quit, because it is very painful, and those thoughts were in my head, too. I wanted to stop, I wanted to quit, because I didn't like how it felt. Yeah, but you know what? Look where I am today, so I'm proof. I'm living proof. I'm that scientific experiment. But I know how it works, and I know that it can work.

Finally, Tonya shared some of her healing journey:

> Definitely my psychiatrist and my therapist, and a coping skills I created for myself, I played cello in high school, and I came up with this one, but I played cello in junior high and high school, and so if I could feel a panic attack coming on, there was one song in particular that was one of my favorite songs and I would make myself do the fingering to that, and focus on doing the fingering to… so it would have to be something like that. I have to distract myself. That is kind

> of what I do now. I try to, if I feel it coming on. I try to distract myself, or I will pick up the phone and call someone, and try to focus on what's going on with them. That's where my therapy is, right now. I introduced that at my last therapy session, I have to work on focusing on what I need. It's time for me to really face my self-esteem issues. Because when you're invisible in your own home. And my father didn't live with us, didn't decide to be my father until I was 13, even though he knew who I was. He adopted someone else's child. And raise that child and brag on him like that was his son.

Subcategory 1 – Opportunities and Safe Spaces To Be Vulnerable. The care after the extended periods of undiagnosed trauma significantly impacted their lives positively, as they continued to seek trauma-informed support that offered safe spaces and allowed for opportunities to be vulnerable with their story. This sentiment was expressed by each participant in various forms; several examples will be shared in this subcategory:

Flora shared her experience with the second counselor:

> Yeah, so I found her. My assessment with her was like an hour and a half long, or 2 hours. My 1st appointment with her was very long. I told her the problems that I had with the 1st therapist that I had tried, and she very much took that into account, and never once made me feel the same. There were never any prescriptions or drugs or anything involved there. She didn't say, you know, you have to stop drinking to try to get through therapy. Yeah, it was with this counselor that I started working on my trauma. It was pretty intense, for the 1st 6

> months I went like twice a week…Yeah, my psychologist down here who did the assessment did a very, very thorough ADHD assessment, and then literally had me in tears at the end of it, when she was like, you've been masking this your entire life, and it has a lot to do with your trauma and everything else, and this and like broke the whole thing down. I was like, Oh, yeah, okay.

Then, after a very long journey through many different attempts to find the right therapy that would work for her, Wanda finally found a trauma-informed therapy that works for her. Wanda shared,

> Then I had found out about this program called Warrior Path. And PATHH is spelled with two H's, and it stands for Progressive and Alternative Training Helping Heroes, and it's a national program. But here in Washington, our local PTSD foundation sends people there, and it's free. So, they do it for veterans and first responders, and I was like, oh shit, here we go again, some lady's going to tell me that I'm bossy, and I'm, like, screwed up, and whatever. I went, and it was completely different. It was not anyone credentialed in anything. It was peer-to-peer, and it was all focused on post-traumatic growth. It was, here's how your job in the military, or your job as a nurse, makes you have perfection, makes you have high alert all the time. Guess what? That's the same symptoms of PTSD. Here's your job training. Here's PTSD. It is the same. Thing! And it's not your fault, and they taught us meditation, and we walked a labyrinth, and we let things go. I got to sit with women who, up until that point, I thought I was the only one who had this. Like, sure, other people had bad sexual things happen. Sure, other people had

people screw them over in a job, whatever, but not like me, you know, I'm special. And that was where I talked to these women, and it was, like, oh my gosh, your story is almost exactly the same, yes. I found my tribe, yes. So that was literally… one year ago this week. I was talking with one of my sisters, and she said, have you heard of metabolic psychiatry? And I was like, what? Like, here's this term again, and so I'm like, okay, I haven't tried this thing. So, I started Googling. I found a counselor. Her website is called Mental Health Keto, and she started meeting with her in September. And she put me on a very, very strict, like, therapeutic ketogenic diet. I did not just eat more fat and fewer carbs. But I ate 77% of my dietary intake was fat, 18% was protein, and 5% or less was carbs. And within 5 days of doing that, I was like, something's different. And so, that was in the middle of September, and then I kind of did this a little bit. And at that point, I was on a medication called low-dose naltrexone. So, I started Googling. I found a counselor. Her website is called Mental Health Keto, and she started meeting with her in September. And she put me on a very, very strict, like, therapeutic ketogenic diet. Do not just eat more fat and fewer carbs. But I ate 77% of my dietary intake was fat, 18% was protein, and 5% or less was carbs. And within 5 days of doing that, I was like, something's different. Yeah, so she said it might be that medication you're on. She said, even though it's not a psychiatric medicine, you're taking it for psychiatric reasons, and most of my people that are on antidepressants or antipsychotics or whatever. Once they hit a therapeutic range, they have to come down on their medication. So I got off of it, and in

> January, I told my friends that I met at the Warrior Path, I was like, I'm really afraid to say this out loud, but I was like, I think the depression that I've had for 24 years is… Gone and since then, I have woken up every day, and I'm like Awesome.

Alice had many trauma-informed health care experiences from the beginning, but the issue was with the follow-up in her story. Alice said,

> My first experience with anything healing was in AA and doing the AA step work, and that made a safe space for the memories to come through.… I had just gotten married and, simultaneously, I started to have spontaneous memories of childhood sexual abuse, and so I sought out therapy, and the first therapy I did around that in sobriety was EMDR…The other thing that they did there was to practice acupuncture and energy work…It was just the luck of that clinic doing cutting-edge research, and I would say that both of those things, in combination, were… I mean, I don't know that I would be here without those things. My life since then, I will tell you, it wasn't like a one-and-done. I am still unpacking all of that stuff, and still growing. I remain open to new memories, to new ways of addressing trauma, and I think I've done almost everything, brain spotting, EMDR, somatic experiencing, acupuncture, massage, acupressure, ayurvedic medicine, holistic medicine, talking circles, sweat lodges, sundances, I've kind of done it all, and each thing that I do that is healing removes another piece of it.

Subcategory 2 – Destigmatizing. Destigmatizing means removing the negative association, causing it to no longer be seen as a stigma. In the context of this paper, the

term encapsulates the transformative process experienced by seven survivors who began to feel a sense of relief following accurate assessments and diagnoses. As their awareness deepened and healing progressed, they gradually recognized that the burdens of shame and guilt were not theirs. This realization allowed them to unburden themselves from the weight of their traumas, enabling them to rediscover their identities and envision the individuals they aspired to become.

Here are some snip-its of their stories. Violet shared,

> Yes, definitely empowering, and that's what made me actually realize. I can. I can do this. I can fight for myself…So, it's been a massive rollercoaster, this entire journey, and just fighting to be heard as a woman. As a veteran, because we get dismissed all the time anyway, oh, you were a nurse. No, I worked on Apache helicopters…Well, plus, I'm finally being seen, heard, and validated instead of gaslit and dismissed. That's healing the whole self-worth thing that I've had for… Decades. It's validating to the younger me, who's like, something's wrong, why isn't anyone taking me seriously? I'm finally being seen for everything that freaking happened to me. It sucked. It was horrible. I never should have had to go through that. And I should have had the help…I'm really, really trying to show my girls that you can follow your dreams and still thrive in society.

Then Karen shared her story:

> That whole self-factualization, at first, I was going to have to come to the realization that I was a child. That shame, guilt, embarrassment, and all those things were not mine. I think that having my own child, seeing how innocent she

> was, and seeing that nothing that she could ever do would cause her to be victimized in any way…I felt empowered, I felt I gained confidence in myself, and I've always had so much self-doubt. And I still do to this day, I do still have some self-doubt, but I know that if I really want to do something, I can do it, so I did feel a sense of empowerment. I felt confident, and it's just like the whole Carl Rogers thing, the self-actualization…I was going around thinking while I was in a children's home, there was around all these other kids who had been damaged and, something was wrong, and so I also saw all this negative stuff, but then I started seeing potential, I started feeling better about myself once I realized that it was not my shame to carry. I had no guilt, because those things didn't belong to me.

Iris said, "I was okay, I can do this. I can do it on my own, I can get there, I can make stuff happen." And finally, Tonya said,

> For the fact that I need space and I need a life. I'm not apologizing for that anymore. And his mental illness cannot be mine…Your diagnosis is not who you are. That's just like saying, well, this is the color of makeup you wear. Or these are, this is who you are. It's not what you have, it's how you deal with it…I think the other thing it's taught me is not to be ashamed of what I've been through. I'm not the only person, and what I've been through may help someone else, so I don't have to hide my story or hide what happened to me.

Category 2 Transforming

All seven participants have experienced tremendous growth (Denise & Sinko, 2019) after receiving their PTSD diagnosis and have been able to change their perspective and narrative regarding their story. They all have words to express how treatment has influenced and transformed their life. Here are some of their empowering statements.

Flora said,

> As far as my everyday life, a lot of times, for the most part, I just kind of go through a normal day, I think a normal person would…It's no longer survival mode or when we go out…Let me go drink to forget, or any of those things, so the change is, it's a complete 180 from who I was and who I could have potentially turned out to be if I hadn't actually had that moment of clarity to get the proper help.

Similarly, Wanda had some words about her growth after her diagnosis of PTSD:

> Wait, can it get better than yesterday? I'm like, this is pretty freaking sweet. And then… It does. It does. It does, it does…Like, I never, NEVER have felt that and having the clarity in my brain to be able to not hate who I was or who I am. It is amazing. Yes, I mean, so much…my relationship with my husband of almost 27 years has never been better, and my relationship with my kids went from being mad at them because they were moving out and being independent, and I felt abandoned to…I've never been closer to them, more proud of them. Great

> relationship…I have a job that I love. I wake up grateful and, like, alive every day, and now I have goals, and I'm going back to school.

The stories of personal growth are not an "automatic" or instant thing; it is a part of the healing process, which Alice explained well:

> My life since then, I will tell you, it wasn't like a one-and-done. I am still unpacking all of that stuff and still growing. I remain open to new memories, to new ways of addressing trauma…I'm doing a whole retreat around it soon, with sound healing, and special kinds of yoga, and all types of stuff…There's learning to trust men again, and learning to love again without being afraid they're going die or abuse me. I did enter into a long, abusive marriage, 15 years, and grew out of that, and then, you know, reading, The Body Keeps the Score, and there are just so many different things that I continue to practice because I want to continue to heal and grow, because ultimately, I would like to have a positive impact on my children's lives and the lives of other women who survived and lived through that, and share my story with them and help them figure out how to get help.

Subcategory 1 – Internalizing Positive Feelings/Emotions. Mirroring the pre-diagnosis subcategory, this subtheme shows the participants' extreme opposite internal emotions and feelings they felt as a positive influence in their lives after diagnosis and treatment. Here are some of their individual statements that reflect these internal feelings.

Violet stated,

> Expansive and comforting…freeing…empowering… fun…transformative…seen, heard, and validated…healing the whole self-worth thing…validating to the

> younger me… now feeling safe enough…I'm no longer in a dark tunnel. I'm no longer in that pit of despair. I left that months ago… I'm moving to thriving… I can see the abundance all around me, and I can actually feel it now, and not feel like I don't deserve it.

Karen shared,

> I felt empowered, I felt, I gained confidence in myself…I know that if I really want to do something, I can do it, so I did feel a sense of empowerment. I felt confident, and it's just like the whole Carl Rogers thing, the self-actualization… liberation…It's like when you're looking through a dirty window and you decide you're going to clean it, and you clean the window, then you see things clearly. You have this clear, and it's like, oh, you know, look at how pretty this is, now that all the dirt is gone, so it's that hope and inspiration, it's a, that everything is going to be okay.

Then Iris shared, "I feel like once I started getting up, there was more color. More just, everything seemed I was okay, I can do this. I can do it on my own, I can get there, I can make stuff happen."

Subcategory 2 – Gaining Perspective and Finding Purpose. Following the diagnosis of PTSD, the treatment influenced the participants' perspective on life and their sense of purpose. Some individuals chose to change careers or return to academia, while others felt more grounded in their current circumstances. Each participant expressed a desire to have a purpose that benefits the well-being of others, which was a motivating

factor in participating in this study. Subcategory 2 presents some of their statements regarding perspective and purpose change.

Tonya shared,

> It definitely makes sure you're aware of how you treat yourself. You hear people talk about self-love, but they never really tell you what that is, and I think that therapy helps you to identify the areas where you need that love. In the areas where you need to treat yourself more gently…I understand better, and so it allowed me to… and I actually have apologized to her for judging her so harshly. In some ways, it made me really realize some of the things that she went through and why she behaved the way that she behaved and why she did some of the things that she did… I want to make a difference…That's part of why I wanted to be a part of it, too, because I feel like everything you go through in life is to help someone else, not just yourself.

Wanda stated,

> I have goals, and I'm going back to school. I'm taking a clinical training course on ketogenic diets for mental health. I am a big advocate and believer in the food as medicine movement…I have just been telling everyone and sharing stuff on social media that if you are struggling. We're all going to struggle, but you can learn how to struggle well and find your network of people. It doesn't matter how low you are; there is hope and healing.

Category 3 Support Is Crucial for Healing

The third theme identified from the post-treatment data highlighted the significance of support in the healing process (Ellis & Wieling, 2024). Having safe spaces where individuals could express vulnerability with trusting people who would validate their experience significantly increased their confidence and diminished internal negative guilt and shame for some, which meant relocating to a different country or state and starting all over, or starting a new career path and undergoing personal reinvention. The analysis revealed that support is inherently individualized and varies for each person; however, promoting openness and facilitating healing remains essential. Let us examine their reflections on how support influenced their lives following their PTSD diagnosis:

Alice shared,

> When I was 25, I was sent to the Meadows in Wickenburg, Arizona, which is another residential treatment center, and this is when I first received actual help. They were so kind and so loving, and it was a therapist who made it feel like a safe place, and they had to help me figure it out, because I didn't understand it…Yeah, and it gives it a purpose, and it helps unite me with this whole group of people who've had the same experience, and then they go out and help other people, and it's kind of a beautiful sense of love and community and healing… I do another program called Adult Children of Alcoholics and Dysfunctional Families, and that also gets to the root of childhood abuse and neglect, and helps you to know, when we're young, we write a story to survive. We tell ourselves a story so we can survive in the traumatic environment that we're raised in.

Virginia's support looked very different:

> My current husband and I have kids; they've been my rock. He's been completely supportive. Of this entire journey, he's got PTSD as well. So, we help each other ground and whatnot…we play Dungeons & Dragons, so we use that kind of like therapy sessions…I'm seeing my counselor, she's actually an intern. I got paired with her because she was open-minded. I want to stick with her; she's awesome.

Karen has had much support along the way, and at times it seemed to Karen as "God sent":

> My weekend house parents at the ranch were young… they had just graduated from college with their degrees. She's a social worker, he's a Marriage and Family Therapist. So, they had just finished with their degrees, and young married couple, but they were funny. They were very special people, and he just made me laugh. He was a very funny person. They were funny together and would make me laugh. So, I guess laughter therapy started being a part of my treatment. When I got released and was able to return, that was March 1st. And my parents were in a car wreck on March 30th, and my mom was killed instantly, and my dad died two weeks later. My house parents from the ranch came to see me after my parents died and ended up taking a job at the children's home in Natchez, where I was, and they became my foster parents. So more people that God just put in my life…(Later, when she got married) My late father-in-law was the one person who allowed me to be able to trust somebody. I trusted Him completely, and I tell people God sent him to me to make up for the bad father that I had.

Iris shared how important support was as she escaped an abusive relationship in the middle of COVID from another country:

> I had one friend who said you need to leave him. You need to leave him. She was really supportive and listened to me and everything. She wasn't rude about it, but she was, like, all that shit is not okay, do you want your daughter to see you treated that way? And I was like, absolutely not, I don't want my daughter to see me treated that way…(recommended a therapist) I had a friend of mine actually recommend somebody, she's like, I've talked with her, she has done a lot to help me work through trauma in my life. I really think it could be beneficial. Just have a chat with her. If you don't click, you can look for somebody else. I think she's great. She and I have really similar personalities, so she's like, I think you would really get along with her well…I'd say, honestly, my girlfriends, they have just been, I have one that's just been my rock, through everything, she's always been there if I needed to talk, she will listen and say, "do I need to come over there and help drag you out?" She was like, I don't care what the COVID restrictions are, I will sort it out, I'll figure out how to get there, I will meet you at the airport if that's what we have to do. She's like, whatever, whatever you need. And I was like, Nope, I can do this myself, I can make it happen.

Discrepencies

Iris's case was the only instance that exhibited slight discrepancies, yet not to a degree warranting her exclusion from the study. Within her narrative, two discrepancies set her apart, offering a valuable opportunity for a more in-depth examination of the

incongruence process (Patton, 2015). In analyzing the data, two significant findings arose from the narratives. Six out of the seven participants reported needing to contact healthcare providers or counselors multiple times over several years to obtain an accurate diagnosis; conversely, Iris sought assistance from a single friend following her departure from an abusive relationship and received a referral that perfectly met her needs. Iris stated,

> Yeah, I had a friend of mine actually recommend somebody, she's like, I've talked with her, she has done a lot to help me work through trauma in my life. I really think it could be beneficial. Just have a chat with her. If you don't click, you can look for somebody else. I think she's great. She and I have really similar personalities, so she's like, I think you would really get along with her well.

However, Iris remained in this relationship for four years, attempting to make it work without seeking assistance from a counselor or therapist. It was only after moving back home and starting therapy that she recognized her partner's behavior closely mirrored that of her mother during her childhood. Another notable distinction in her case was that Iris had not been diagnosed with any other conditions prior to receiving her trauma diagnosis. These two discrepancies did not influence the overall findings, as most of the data points aligned with those of the other participants and were pertinent to the study.

Looking Glass Self

Charmaz et al. (2018) examined the evolution of self through symbolic interactionism, resonating with me as I engaged with the narratives and processed the

coding. Charles Horton Cooley's concept of the "Looking Glass Self" articulates how individuals perceive themselves, considering how they believe others perceive them. Consequently, individuals interpret how others must perceive them, often leading to a distorted self-image rooted in these beliefs. This process ultimately creates the lens through which they view themselves, resulting in either a negative or positive self-view. Such reflections, whether grounded in reality or merely imagined, can profoundly impact individuals who have experienced trauma, particularly when such trauma occurs at a young age and goes on for a long time without appropriate interventions. Each participant expressed self-identification marked by negative emotions, detrimental self-talk, external behavior issues, and complex relationships. Despite this, an intrinsic motivation persistently drove them to seek assistance, as Karen articulated, they desired to "clean their looking glass." Notably, upon receiving an accurate diagnosis and the validation they deserved, these individuals began to witness a transformation in their narratives and perspectives. Their "looking glass self" began to evolve, leading to a reconfiguration of self-interpretation grounded in affirmation rather than shame, clarity instead of guilt, and therapeutic engagement as opposed to dismissal. The process of "cleaning the looking glass self" commenced, initiating their healing journey, and gradually, each individual progressed from mere survival to a state of thriving, or is getting close to achieving it.

Summary

This qualitative grounded theory study aimed to understand how women who have prolonged undiagnosed PTSD navigate the treatment process, as well as how the treatment subsequently influenced their lives. From the data analysis, two global

categories, along with six categories and eleven subcategories, emerged from the data, identifying the challenges these women faced in reclaiming their voices throughout the process, the obstacles posed by the existing systems, and the isolation often felt at the onset of their journey. Driven by an unwavering determination to improve their lives and those of their families, they persistently sought answers that resonated with them until the proper assessments were done to lead to diagnoses. Ultimately, at the journey's crossroads, they found the process of healing, characterized by personalized care and support, enabling them to grow and evolve into the individuals they aspired to become and beyond. They cultivated purpose and confidence in their previously silenced voices by learning to process feelings and emotions constructively and advocating for themselves and others.

Finally, exploring how personal perspectives influence understanding of surroundings plays a crucial role in healing. Women across the world are increasingly experiencing the repercussions of unrecognized trauma, highlighting the urgent need for transformation within specific societal frameworks and the messaging conveyed to the global population. In Chapter 5, I address the analysis of the findings, acknowledge the study's limitations, propose avenues for future research, discuss the implications for social change regarding accurate trauma diagnosis and treatment, and provide the concluding remarks of this research study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The objective of this CGT study was to understand the process of women aged 40 to 60 in obtaining treatment for prolonged undiagnosed PTSD, as well as the effects of this treatment on their lives. I sought to uncover the participants' experiences with the treatment process and the repercussions of not receiving appropriate care, followed by the impact of finally obtaining the necessary treatment. The study revealed two overarching global categories, supported by six categories and 11 subcategories, highlighting the significant challenges these women faced in reclaiming their voices, overcoming systemic obstacles, and coping with the isolation often experienced at the beginning of their journeys. Motivated by a strong determination to improve their own lives and those of their families, these women persistently sought meaningful answers until they received accurate diagnoses through proper assessments. At a pivotal point in their journeys, they encountered healing characterized by personalized care and support, which empowered them to grow, evolve, and embrace the individuals they aspired to be. By learning to process emotions constructively and advocate for themselves and others, they found renewed purpose and confidence in their once-silenced voices. Chapter 4 also examined how personal perspectives influence one's understanding of their environment, a critical element in the healing process. As women worldwide increasingly suffer the effects of unrecognized trauma, this study underscores the urgent need for systemic transformation and improved societal messaging about trauma diagnosis and treatment. Here, I will also

discuss the study's limitations, suggest directions for future research, explore implications for social change, and offer concluding reflections on this important work.

Interpretation of the Findings

Prior to conducting this study, I assumed that women experiencing prolonged, undiagnosed trauma, hailing from diverse backgrounds and various regions of the country, would exhibit commonalities in terms of their narratives regarding their processes of trying to obtain treatment for PTSD. I also hypothesized that the impact of finally receiving treatment would manifest in similar ways across their lives. Upon analyzing seven rich narratives of trauma survivors, many similarities were identified in their stories.

The findings align closely with those presented by Gagnon-Sanschagrin (2022), indicating co-morbid diagnoses. However, if additional assessments had been conducted appropriately and timely, as suggested by Cogan et al. (2021), the correct diagnosis would have led to the correct diagnosis and might have avoided the emergence of co-morbid conditions. This also corroborates the literature by Gagnon-Sanschagrin (2022), which utilized machine learning to identify PTSD diagnosis in records where PTSD had initially gone undetected. Furthermore, this study reinforces the conclusions drawn by Barrett and Currin (2024), highlighting that PTSD produces varying effects across different cultures and demographic groups, often resulting in negative stigma, shame, and fear that impede disclosure of sexual assault among women of all ages. Such factors can exacerbate symptoms, delay access to necessary care, and obstruct effective treatment, which brings forth negative stigma, shame, and fear, causing women not to disclose

sexual assault or domestic violence. This can lead to escalating symptoms, a longer wait to receive help, and hinder appropriate treatment.

Evidence from this study supports findings by Menculini et al. (2021) regarding the trauma experienced by frontline healthcare workers during the COVID-19 pandemic, particularly within the mental health sector. Additionally, supporting data emphasized the critical need for thorough PTSD assessments (Agha et al., 2024; Magwood et al., 2022; Venkatachalam et al., 2023) and the importance of creating safe environments where individuals feel comfortable sharing their narratives to uncover histories of PTSD or trauma. This study also addressed the inadequacies of personalized care and the insufficient awareness among general practitioners concerning the management of untreated mental health disorders (see Papachristopoulos et al., 2023), alongside the increased risks of substance use (see Colovonen et al., 2022) and ADHD (see Wendt et al., 2023).

Moreover, this research highlighted the imperative need for healthcare to conduct PTSD assessments during prepartum and postpartum periods to adequately support mothers and their children during this crucial phase (see Beck, 2023). It also underscored the value of assessments that incorporate written narratives and supportive language for trauma survivors, addressing the communication barriers often encountered during traumatic experiences (see Keedle, 2022). The study acknowledged the impact of generational trauma, as established by Agha et al. (2024) and Matoba (2023), and how these intergenerational beliefs can adversely influence trust in external help-seeking during early development years.

This study resonated with Peters's (2021) findings, indicating that women in the military experience sexual trauma yet often perceive a lack of support in that environment, leading to underreporting. Additionally, it paralleled Detert et al. (2019), who pointed out that many female veterans with PTSD symptoms must navigate numerous barriers within military healthcare to obtain care for undiagnosed PTSD. The findings revealed that unrecognized trauma can profoundly shift individuals' self-perceptions due to internalized guilt and shame imposed by their abusers and their surrounding environments, aligning with Spytska (2023).

Moreover, this study affirmed the current literature's implications – though not explicitly stated – that there is no singular, definitive "treatment plan" for PTSD or trauma. Through this research, a variety of effective therapeutic modalities, including natural and holistic adjuncts supporting ongoing treatment, are identified. Finally, the findings echo those of Ellis and Wieling (2024), Edwards et al. (2021), and Baenziger et al. (2023), which emphasized that connecting with others who share similar experiences, engaging in dialogue, and fostering healing relationships collectively contribute to the healing process.

Limitations of the Study

I adhered to the procedures outlined in CGT, including initial coding -- whether conducted on a word-by-word or line-by-line basis – followed by general and axial coding, memo writing (either clustering or free-writing), journaling, coding for categories and subcategories, as detailed by Charmaz (2009). To validate findings and address potential limitations and biases, I utilized checklists and guidelines as suggested by

Charmaz and Thornberg (2021). This included a commitment to self-awareness and maintaining an open analytic perspective on the existing literature within the field, alongside engaging in reflexive journaling throughout the coding process. The potential impact of recalling sensitive memories on interpreting the research outcomes was acknowledged. Participants were prompted through the questions that fully utilized the allotted 90-minute timeframe, allowing them to share in-depth and richly detailed information that significantly contributed to the existing body of literature.

Weaknesses also included the limited diversity within the sample population, predominantly comprising Caucasian American women, with only one participant representing a woman of color. A more heterogeneous sample could yield distinct insights regarding the treatment experience for prolonged, untreated PTSD among women. Moreover, the study's credibility could be enhanced by involving multiple interviewers and conducting separate analyses of transcripts, comparing interpretations among reviewers to ensure accuracy. Additionally, conducting a similar investigation encompassing different age demographics would provide further insights, as would research focused on male participants.

Recommendations

Strengths of this study lie in its utilization of an intensive interview approach, which facilitated the collection of detailed and unique narratives from women aged 40 to 60 who have experienced prolonged undiagnosed PTSD. This approach enabled an exploration of how the journey towards receiving treatment for PTSD has influenced their lives. Reliant on statistical data, quantitative methods would likely have missed the

nuanced feelings, emotions, and intricate experiences these seven survivors navigated to arrive at their current state. This intensive interviewing process created a secure environment wherein participants could articulate their experiences framed through a perspective of survival and resilience.

Implications

This study is significant with a multifaceted approach for social change because it fills a gap in the literature by providing deeper insight into the highly challenging process for women to get validation for their story when they share with their families and the reporting systems in our communities, to receive a proper diagnosis for PTSD in our healthcare system and within the military, and the changes that need to be made socially to reduce the stigma attached to asking for help. There is a desperate need for an international measurement to create international change for how to ask children if they are safe at home, and visible help for women to reach out from domestic abuse.

The hope is that this study will shine a light on this population and increase awareness that the process is failing years before this age group. It is failing when they were very young, and the process has lasted far longer than it needed to. Incorporating more mental health awareness in our school systems and normalizing talking about mental wellness early, so it is not something that is attached to guilt and shame. This education, including awareness at doctor appointments or required in parenting classes, could help society become more educated on the generational curses we unintentionally hand down, potentially creating generational change.

Another impact is that counselors and medical professionals have more trauma-informed classes in their master's programs, so they are more prepared to support and assess properly. Existing counselors in the field should consider taking additional classes to ensure they are correctly working within their scope when working with clients who have symptoms of trauma and be honest with themselves and their clients when it is not.

Conclusion

PTSD and trauma, while profoundly challenging, are conditions from which individuals can recover and ultimately lead fulfilling, extraordinary lives. However, when these conditions remain undiagnosed for years, they can result in significant and adverse effects, forcing survivors to endure the impact of trauma far longer than necessary. Systemic failures—such as inadequate assessments, insufficient investigations of abuse allegations, neglect of visible injuries in children within school settings, disregard for sexual assault cases in the military, and lack of accessible resources for women experiencing domestic violence—exacerbate the harm experienced during these undiagnosed intervals, often causing more damage than the initial traumatic events themselves. The processes of the seven women in this study highlight systemic shortcomings, which are unacceptable and demand urgent reform. This research strongly indicated that once survivors receive accurate diagnoses, validation, appropriate treatment, and feel genuinely heard, the healing process can start, with authentic recovery. This qualitative study answered the questions of how women who had prolonged undiagnosed PTSD experienced the treatment process and how the treatment influenced their lives.

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Appendix A: Invitational Flyer

This Interview study seeks Women aged 40-60 who have completed treatment for enduring undiagnosed PTSD or trauma for at least one year.

- There is a new research study about the processes of women who have endured undiagnosed PTSD or trauma for over a year and then received treatment, and how that impacted their lives.
- You are invited to share your experience to provide valuable information that can be used to identify areas where women require support and to design plans to change the healthcare and education system.

Criteria:

- Women from the ages of 40 -60
- Have completed counseling or treatment for PTSD or trauma
- Went undiagnosed for PTSD or trauma for at least one year
- English speaking
- Consent to at least one video interview that is audio recorded and possibly a follow-up phone call later in the research process.
- To protect privacy, interviews will be conducted using a secured media connection and the names will be changed for the published study.

This interview is part of the doctoral study for Kelli Hudgins, a Ph.D. student at Walden University

Interviews will take place during May through July 2025

To volunteer confidentially, contact the researcher, Kelli Hudgins, at XXX@waldenu.edu or message me on the social platform where you found this invitation.

Appendix B: Interview Guide

The narratives of women aged 40-60 who endured prolonged PTSD or trauma and the process of receiving the proper treatment and the impact it had on their lives.

Interview Guide

Introduction

Thank you for agreeing to do this interview with me. Please take the time to review the consent form again and ask any questions or voice any concerns that you may have before we get started. As a reminder, this interview will be audio recorded so I can accurately transcribe the conversation for the purposes of the study. Any time during this interview you can request to take a pause or to stop if the questions become too difficult. This is your right as a participant, and the interview is entirely optional.

This is your time and space to share your story with me. My job is to represent your journey and the meanings you make from those as a way for others to learn more about the impact of undiagnosed PTSD and trauma, the process of receiving proper treatment, and the impact it had on your life.

Research Questions:

In what manner do women who have endured extended periods of undiagnosed PTSD or trauma perceive the therapeutic process? Additionally, in what ways has the treatment impacted their lives?

1. What can you tell me about when you felt that something was not right, and what was your process in exploring those feelings?
2. What was the process with the healthcare system?

3. What other diagnosis were you given before finally being diagnosed with PTSD or trauma?
4. How long was the time frame from when you started this journey and when you finally received treatment for PTSD?
    a. What was that process like for you?
5. What kept you seeking help or continuing to look for the answer?
    a. Can you share specific thoughts or events?
    b. What does this change mean to you?
    c. How did you cope with the challenges?
6. How did treatment change your daily interactions and routines in your life?
    a. Share specifics with your family, work, interpersonally, social events, etc.
    b. How has the change affected your family and friends, and how do you feel about yourself?
    c. What support systems have been the most helpful during this process?
    d. If you didn't have any – what support system would you have liked?
7. Can you compare or explain the before and after of being properly diagnosed and receiving treatment – how did it change your perspective of life?
8. Reflecting back – what would you do differently if you could go back and apply what you know now to you back then?
    a. At what age do you think this education or information would have made a difference to you?

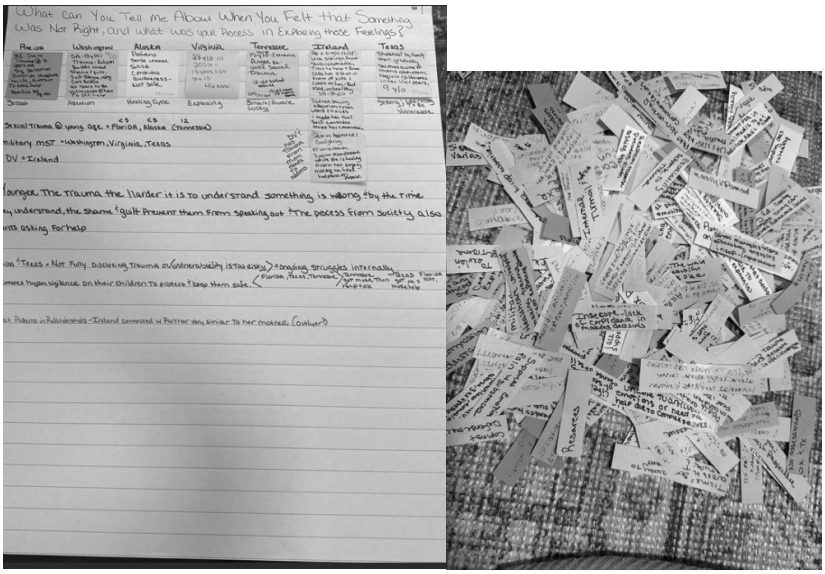
9. What is your opinion on what can be changed to help the healthcare system be more trauma-informed when it comes to uncovering PTSD and trauma?
10. Share some words for me that describe the before and after for you – How did you feel before the correct diagnosis and treatment, and how did you feel afterward?
11. Is there anything else you would like to share to help advocate for uncovering PTSD or trauma more effectively?
    a. Is there anything more you would like to share that I have not asked you today?

Conclusion

Thank you so much for sharing your story and your time with me. I will listen to our audio recording many times in an effort to accurately transcribe your story for the study's purpose. I would like to give you an opportunity to review what I have transcribed before any analysis or conclusions are made. Would you be willing to review the transcription? Great. Thank you. I will email the transcribed interview recording using an encrypted email in a few days. In the meantime, feel free to call or email me with any questions or concerns you have about today's interview or about this study in general. I am also going to leave a contact number for additional support because the things we discussed today can bring up strong emotions. How are you feeling now that we are done with the interview? Thank you again for sharing your stories and your time with me.

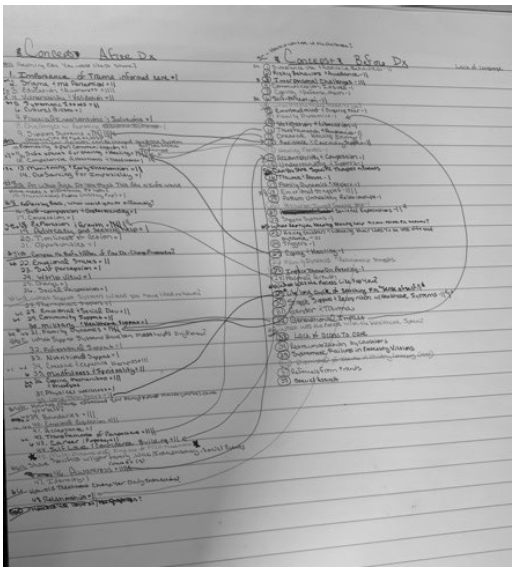
Appendix C: Examples of Coding, Categories, & Subcategories Development

Social Interactionism Lens	Axial Coding	Focused Coding	Initial/Open Codes	Interview Statement
	Post It notes Pics		Asking for clarification.	Yes, my only question is, as far as abuse is, this whole thing is literally about that. From my childhood.
g 150 SI - All Our Families	#1 Due to trauma @ 5 y/o significant perception distortion throughout her life; resistant to seek help	Experiencing sexual trauma at a young age, such as five, can significantly distort an individual's perception of social interactions and personal development. This trauma may lead to difficulties in forming trusting relationships, understanding healthy boundaries, and processing emotions. As a result, the affected person might struggle with feelings of shame, anxiety, or isolation, impacting their overall social functioning and mental	misaligned realization; incongruent and concerned	When something was not right. Oh, gosh! I mean, realistically, something started off not right when I was 5 or 6 years old.
			wanting to act but hesitant, unprepared	That's when the abuse started, and, I will say it wasn't until my kind of early to mid-twenties that I decided I should probably try to do something about it, and then, even from there, I still was not quite totally ready, and I didn't fully get the help I needed to get until I was about 31.
			Effort to process	It was very much a process.
			Endure due to livlihood and family connections	Because the abuse lasted so long. And also, I think, children who go through abuse at a young age, and you kind of realize that at the end of the day, like this is my abuser, but this is also our livelihood.
			Carry burden alone; protect mom	It's a very heavy burden and weight to carry as a kid. But even once the abuse stopped, I knew that like this is very much our livelihood. For my mom and me, there was a lot of weight taken on with that.
I Pg 48 Social: Becoming ourselves		her experience highlights the pervasive effects of sexual trauma on emotional expression and interpersonal relationships. During her teenage years and into her twenties, she grappled with a strong desire to disclose her trauma but felt unprepared to face potential consequences. Her belief that revealing the abuse could endanger her family's stability led to deep-seated guilt	Supress emotions; self medicate, unleash emotions unintentionally	I kind of just suppressed everything and moved on with life, and then hit my early twenties, and it was never really much of a party or drinker, but then I started working at the bars. Then the alcohol started, and, as everyone knows, with alcohol starting, then came out all of these suppressed emotions all of the time.




How Did it Influence Their Life?


Process Before Dx PTSD


Concepts After Dx
Concepts Before Dx