**INTRODUCTION**

- Background: for last 40 years, individuals with disorders resulting from trauma — were diagnosed and treated for PTSD; but in reality, there are two separate conditions: PTSD and CPTSD

- Mental Health Stigma: individuals with psychiatric conditions are stigmatized in American society; people who do NOT respond to psychiatric treatment are further stigmatized as “incurable” or “treatment resistant” or “noncompliant”

- Social Problem: What happens to people who live with psychiatric disorder if they are misdiagnosed or never diagnosed for that disorder?

- Contribution: deepens understanding of those stigmatized as a result of a trauma-related psychiatric disorder and having a misdiagnosis/lack of diagnosis for that disorder; encourages a re-evaluation of behavioral expectations in educational and healthcare settings

**BACKGROUND - TRAUMA**

A DISTRESSING EVENT WITH LITTLE OR NO MEANS OF ESCAPE OR CONTROL (Cicchetti and Rogosh 2001; Garo, Allen, Handy, and Lewis 2018)

- Consequence of trauma: for some (but not all) - life altering changes to physical, mental and emotional health (Cicchetti and Rogosh 2001; Nienkern et al. 2016)

- PTSD (1990): official diagnosis associated with Vietnam Vets; adding an unofficial “c” to explain differing symptomologies (Cicchetti and Rogosh 2001; Sanchez et al. 2010; Rincon-Correa et al. 2015)

- CPTSD (2018): second, distinct diagnosis of psychiatric disorder describing additional set of life alterations as result of trauma (Butcher et al., 2015; Nienkern et al., 2016; Ford et al., 2017)

**WOMXN TRAUMA SURVIVORS**

- Social construction of gender group embedded in historical hierarchy of roles and expectations
- History of normalized violence against women to maintain hierarchy & expectations
- Combo of gender marginalization & exposure to violence likely to have psychiatric diagnosis

**STIGMA, TRAUMA , INTERSECTIONALITY**

**BACKGROUND - STIGMA**

THE EXPERIENCE OF SHAME, BLAME, SECRECY AND ISOLATION (Rosenfeld 1997; Byrne 2000; Hatzenbuehler et al. 2013)

- Exists as a function of labeling
- Enables creation of a continual and reoccurring oppressive mechanism in marginalized populations
- Meets all criteria of fundamental cause of health inequalities
- Disrupts/hibits access to multiple resources

**RESULTS**

**RESEARCH QUESTIONS**

**GIVEN THE JUNE 2018 RECLASSIFICATION OF CPTSD AND PTSD AS TWO SEPARATE AND DISTINCT DIAGNOSES:**

1. **How are the symptomologies of each diagnosis expressed differently in the lived experiences of women trauma survivors?**

2. **How does the trauma of marginalized populations and the resulting recurring stigma differently impact education, health services, and life opportunities dependent on diagnosis or misdiagnosis?**

**METHODS**

Data Collection: semi-structured interviews conducted on Zoom

- 5: 10 women identifying as trauma survivors
- Self-assessments of lived experiences, barriers to educational attainment, health services, and life opportunities

Data Analysis: qualitative data analysis software NVivo

- Closed coding to establish PTSD or CPTSD symptomology; educational experiences; health services treatment; and career goal outcomes
- Open coding to identify other relevant themes

**STRENGTHS AND LIMITATIONS**

- Methodological Justification: qualitative methods most appropriate for understanding lived experiences of a social phenomenon that is understudied; most appropriate for studying intersectional lived experiences

- Strengths of study design: sample group consists of marginalized population prone to stigmatization and mental; data is a primary source directly from participants; Pandemic required Zoom interviews which allowed for closed video, encouraging detailed self-reporting during participation

- Limitations of study design: small sample size minimizes generalizability; potential re-triggering of participants

**REFERENCES**


**IMPLICATIONS**

A deeper understanding of those stigmatized with undiagnosed or misdiagnosed trauma-related disorders encourages a re-evaluation of behavioral expectations in educational and health care settings.

**SUMMARY & CONCLUSION**

**RESULTS**

**INDIVIDUALS WHO DESCRIBED MEETING THE CPTSD SYMPTOMOLOGY**

- Reported higher rates of avoidance of medical intervention (due to their “lack of understanding”)
- Reported lower educational attainment or delayed educational attainment (due to stigmatization of peers and/or abuser)
- Reported unfulfilled personal career goals (due to lack of educational attainment and low self-esteem)

**INDIVIDUALS WHO DESCRIBED MEETING THE PTSD SYMPTOMOLOGY**

- Reported lower rates of avoidance of medical intervention (than CPTSD)
- Reported higher educational attainment (than CPTSD)
- Reported higher fulfillment of personal career goals (than CPTSD)

**PHASE II: REFUGEE WOMXN**

Phase II: Sample size of 5-10 womxn refugees

- RQ: How are the symptomologies of each diagnosis expressed differently in the lived experiences of women refugees?
- RQ: How does the trauma of those marginalized populations and the resulting recurring stigma differently impact education, health services, and life opportunities dependent on diagnosis or misdiagnosis

**ACKNOWLEDGEMENTS**

Faculty Advisor: Dr. Heather Evans
Second Advisor: Maria Vignau-Loria
Sociology Honors Staff: Professor Curran & Steven Karceski
Sociology Assistance Grant
Mary Gates Research Scholarship
Pamela E. Yee - Gender and Disabilities Award

The Effects of Stigma as Experienced by Vulnerable Populations in Light of the Reclassification of CPTSD and PTSD