

From Cumulative Strain to Available Resources: A Narrative Case Study of the Potential Effects of New Trauma Exposure on Recovery

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Abstract

This article presents a narrative case study of a client with a history of multiple traumas and severe symptomatology, coupled with an ongoing recovery process. A hermeneutical–phenomenological approach was used to analyze two interviews with the participant over a period of 1 year, following a trauma treatment program. Her husband’s suicide in between the two interviews allowed for an exploration of the possible effects of new trauma exposure on the process of recovery. Analysis of the data revealed how the participant’s early trauma experiences had resulted in escalating symptomatology. Through her relationship with her husband, she gradually became ready to engage in therapy in a way that allowed her to benefit from it. Her husband’s suicide forced her to reconsider her own part in her recovery, resulting in a strengthened feeling of inner security and self-efficacy parallel to what is seen in posttraumatic growth. The results contribute our understanding of individual processes of change and recovery, including processes of growth following cumulative trauma. Plausible mechanisms for growth in the present case was the ability to

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recognize and tolerate feelings, making sense of one's own reactions, as well as a sense of control and trust in available resources.

Keywords

child abuse, recovery, adaptation, enduring coping, users' experiences, trauma

In this narrative case study, we present the case of Petra, a woman in her 30s who over a period of time had progressed in her recovery from childhood trauma, until her husband suddenly and unexpectedly took his own life. Through her story, we shed light on how new trauma exposure may influence the process of recovery following multiple childhood trauma.

Researchers exploring the lifetime exposure to adverse life experiences in the general population have consistently reported a high prevalence of potentially traumatic experiences (PTE) over the life span. In North America, the majority of subjects in several studies report having been exposed to such experiences (Elliott, 1997), even at a young age (Copeland, Keeler, Angold, & Costello, 2007; Finkelhor, Omrod, & Turner, 2009). Similarly, researchers reported a lifetime exposure of 64% to PTE in a representative sample in six European countries (Darves-Bornoz et al., 2008).

Although researchers consistently report a high prevalence of exposure to PTE, the concept of *trauma* is much debated as it is used in a variety of different ways and in different contexts. In everyday language, the term is associated with one experiencing a very dramatic or scary event. The term *trauma* within the field of psychology, however, has a somewhat more specific meaning, requiring exposure to a PTE accompanied with a strong reaction to this exposure. The two main diagnostic systems used in the Western world, the International Classification of Disease (ICD-10; WHO, 1993) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013), define *trauma* as exposure to “a stressful event or situation (either short- or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone” (WHO, 1993, p. 99), and experiencing, witnessing, or learning that a close family member or friend has experienced an event involving actual or threatened death, serious injury, or sexual violence (APA, 2013, p. 271), respectively.

Persons exposed to PTE, which have resulted in an experienced trauma, often report a constellation of symptoms labeled posttraumatic stress disorder (WHO, 1993) characterized by persistent avoidance of trauma-related stimuli, reexperiencing the traumatic event, and symptoms of heightened physiological arousal that interfere with the ability to function in everyday life. Persons exposed to early, relational, and long-lasting trauma often experience a wider range of trauma-related problems including attachment issues, dissociation, difficulties with regulating emotions, strong bodily reactions, and shattered assumptions about

themselves, the world, and other people (Courtois & Ford, 2009; Herman, 1992; Janoff-Bulman, 1992; Ogden, Minton, & Pain, 2006). Researchers have also reported an elevated risk for nontrauma-specific mental health problems (Amstadter, Aggen, Knudsen, Reichborn-Kjennerud, & Kendler, 2012; Chapman et al., 2004; Chen et al., 2010) and somatic health problem conditions (Mulvihill, 2005; Paras et al., 2009) following exposure to PTE. Researchers have also reported that exposure to PTE in childhood is associated with an increased risk for exposure to PTE later in life, and children exposed to one type of abuse are often also exposed to other types of PTE (Olafson, 2011; Tjalden & Thoennes, 2000). Exposure to multiple traumas is in turn associated with an elevated risk of health problems, possibly through a dose-response effect (Anda et al., 2006).

The sudden death of a significant other is without doubt a potential traumatic experience (i.e., APA, 2013, p. 271). The question of whether bereavement after suicide differs from mourning after other types of deaths is unsettled (e.g., Jordan, 2001). Clark (2001) summarizes the literature on bereavement after suicide. One of several conclusions she makes is that families that had previously regarded themselves as functioning well, and in which the suicide comes as an unexpected disaster, are at risk for greater difficulties. Some researchers suggest that there are some distinct ways in which suicide bereavement differs from other losses. For instance, Jordan (2001) points to the thematic content of the grief, which includes a greater struggle around questions of meaning making around the death, stronger feelings of guilt, blame and responsibility of the death, as well as heightened feelings of rejection by the loved one, along with anger toward the deceased. Overall, clinicians and researchers seem to agree that sudden and traumatic death is in general associated with posttraumatic reactions and complicated mourning (Clark, 2001; Dyregrov, Nordanger, & Dyregrov, 2003), including physical illness, depression and anxiety, substance abuse, and family breakdown (Clark, 2001; Parkes, 1998).

Complementing lines of research have focused on how struggling with coming to terms with traumatic experiences also can lead to posttraumatic growth (PTG), with positive changes in self-perception, interpersonal relationships, and an altered life philosophy (Davis, Wohl, & Verberg, 2007; Neimeyer, 2006; Tedeschi & Calhoun, 1996), with engagement with new possibilities proposed as a possible mechanism of growth after adversity (Roepke & Seligman, 2015). Research projects exploring trauma recovery from the first-person perspective report that survivors describe it as a long and demanding process that does not necessarily have an end (Murphy, Moynihan, & Banyard, 2009); a process which involves making sense of their experiences, relating to significant others, creating a safe place for themselves, and reevaluating the self (Draucker et al., 2009), but also with an increased sense of agency (Stige, Binder, Rosenvinge, & Træen, 2013; Harvey, Mishler, Koenen, & Harney, 2000; Phillips & Daniluk, 2004). The strength of a person's sense of coherence (SOC), determined by the comprehensibility, manageability, and meaningfulness

of life experiences, has also received attention in relation to how people react to encounters with stressors (Antonovsky, 1987, p. 12).

Given the increased risk of later traumatization following childhood trauma, the possible additive effect of multiple traumas, and the long and complex process of trauma recovery, we were interested in how new trauma may influence the process of recovery following childhood trauma. We have been unable to locate any case studies on suicide bereavement or studies on the potential additive effect of suicide on survivors who previously have experienced multiple traumas. In this article, we shed light on this research question by presenting the case of Petra, a woman in her 30s who over a period of time had progressed in her recovery from childhood trauma, until her husband suddenly and unexpectedly took his own life.

Methods

Case Selection

The present case was strategically selected from a sample of 13 cases comprising a larger project, which explores the client perspective of trauma treatment and recovery. All participants had attended trauma-focused group treatment. The treatment approach consisted of 17 group sessions focusing on understanding and handling of trauma-specific problems. In each group session, there was alternation between psycho education, skill training, and the sharing of experiences between clients (Stige, 2011).

Participants were interviewed twice; once upon completion of the trauma-focused group treatment, followed by another 1 year after completion. Published results from this project include the process leading to help-seeking following childhood trauma (Stige, Træen, & Rosenvinge, 2013), client experiences of attending trauma-focused group treatment (Stige, Rosenvinge, & Træen, 2013), and the process of recovery, as experienced upon completion of group treatment (Stige, Binder, Rosenvinge, & Træen, 2013).

In accordance with our intention to explore how new trauma might influence the recovery process after traumatization, we strategically selected a relevant case where the participant experienced a new trauma in the period between the two interviews. There were no other cases in the sample that reported potential traumatic experiences in the same period.

The selection of an exceptional case, where the participant experienced losing her husband unexpectedly between the first and second interview, was thus deemed appropriate for an in-depth narrative analysis of the recovery process and possible effects of new trauma. The aim of a narrative case is to convey the experience of the client and “tell her story,” rather than develop theory, evaluate outcome, or document professional knowledge, as other types of case studies aim at (McLeod, 2010). In this article, our main concern is not to evaluate Petra’s

Table 1. Petra's Scores and Group Means on Quantitative Measures at the Beginning of Treatment, End of Treatment, and 1 Year After Treatment Completion.

Instrument	T1 (Start of treatment)		T2 (End of treatment)		T3 (1 Year after treatment)	
	Group mean (SD)	Petra's score	Group mean (SD)	Petra's score	Group mean (SD)	Petra's score
Number of traumas	11.7 (4.25)	9	–	–	–	–
Age at first trauma	3.15 (3.16)	4	–	–	–	–
BDI	27.4 (10.7)	21	16.9 (10.5)	11	15.7 (8.8)	14
IES	50.7 (14.0)	42	39.7 (18.2)	22	29.6 (21.1)	0
PTSS-16	2.5 (.53)	2.0	2.0 (.62)	1.25	1.9 (.48)	1.7

BDI = Beck Depression Inventory; IES = Impact of Event Scale; PTSS = Post Traumatic Symptom Scale.

response on trauma treatment but rather to explore her subjective experience of recovery over time and how a new trauma influenced this process. Table 1 compares the group means (all participants in the six treatment groups participants were recruited from) with Petra's scores on quantitative measures of trauma exposure (The Traumatic Experience Checklist; Nijenhuis, Van der Hart, & Kruger, 2002), depressive symptoms (Beck Depression Inventory-II; Beck, Steer, & Brown, 1996), and posttraumatic symptoms (Impact of Event Scale; Horowitz, Wilner, & Alvarez, 1979 and the Post Traumatic Symptom Scale 16; Mollica et al., 1992). As evident in the table, Petra's scores at the beginning of treatment were around the group mean. Petra did, however, have a larger reduction in posttraumatic symptoms from T1 to T2 and T3 than the group at large.

Authors

Both authors are psychologists and researchers and share an engagement in the understanding and treatment of trauma, and in facilitating integration between psychotherapy research and clinical practice. The first author (SHS) has a PhD in clinical psychology and 8 years of psychotherapeutic experience. Her theoretical orientation might be described as integrative, drawing on humanistic, cognitive, and systemic approaches. She has a special interest in trauma treatment and is, among others, trained in phase-oriented trauma treatment (Herman, 1992; van der Hart, Nijenhuis, & Steele, 2006). She has developed and run trauma-focused treatment groups (Stige, 2011) and led the research project from which the present case was drawn. The first author carried out the interviews. The second author (MSH) is an associate professor and a consultant clinical psychologist. She has 14 years of psychotherapeutic experience. Her theoretical orientation might be described as integrative, theoretically

informed by psychodynamic, developmental, humanistic and cognitive approaches. She is, among others, trained in phase-oriented trauma treatment and sensorimotor psychotherapy for trauma treatment (Ogden et al., 2006). The second author was invited into the analysis of this case after the data collection was completed and has no other role in the research project.

Ethical Considerations

The participant was included in the larger research project through routines approved by the Regional Committee for Medical and Health Research Ethics (REK). Because all potential participants met criteria for receiving specialized mental health services in the public health-care system and were currently undergoing treatment, REK required that all project information be kept confidential until group treatment was completed. Potential participants received information by mail approximately three weeks after completing group treatment. Those interested in participating had to actively respond by replying by mail. Informed consent was given at the time of the first interview. Data were stored according to a license awarded by the Norwegian Social Science Data Service. Details about the participant have been transformed to provide anonymity.

Data Collection and Data Material

In carrying out a case study, it is necessary to build up a rich case record (McLeod, 2010). In presenting this case, we are relying on 3 hr and 45 min of interview data from two semistructured interviews with Petra. The first author, who had not been a therapist for Petra, conducted both interviews. The interview style was open and explorative, introducing open questions then following the participants' initiative. In both interviews, Petra drove the interviews forward, so the interviewer only introduced a first opening question ("Can you tell me, in your own words, how you experienced participating in the stabilization group?" in the first interview, and "Now that you have gotten some distance to the group therapy, how do you view the process you went through?" in the second interview), then following Petra's initiative and story with follow-up questions, aiming at eliciting as rich descriptions as possible of her experiences of help-seeking, treatment participation, and recovery.

In addition to the interview material, Petra drew a time line during her first interview, in which she marked earlier traumatic experiences and fluctuations in distress over time (see Figure 1).

Given that Petra had participated in trauma-focused treatment, REK mandated that details of Petra's previous trauma history were not to be addressed during the interviews. This was probably required due to an anticipated risk of retraumatization. We did, however, acquire consent to use standardized forms used in her treatment, mapping trauma exposure and symptom load at the start

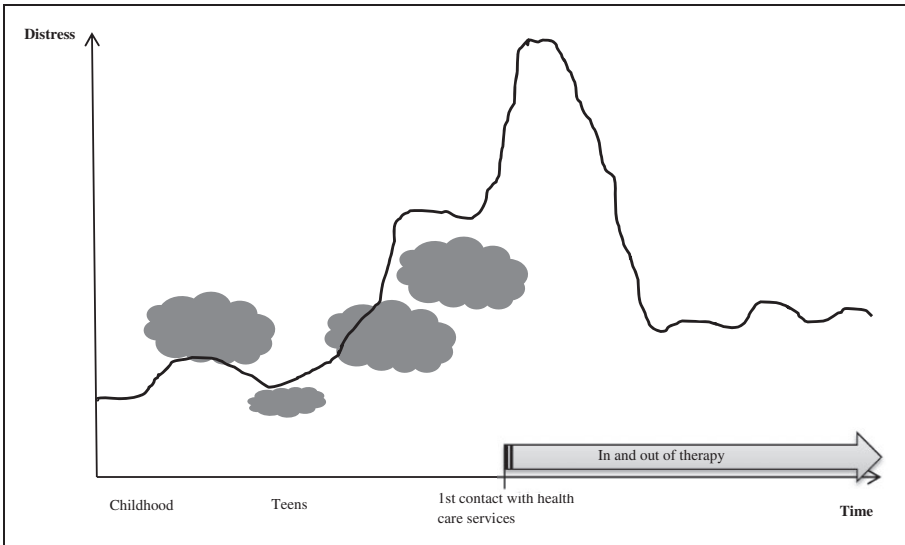


Figure 1. Petra's time line. The figure is a replication of Petra's time line, drawn in the first interview. Clouds indicate traumatic exposure, while the graph indicates her experienced level of distress and fluctuation in distress over time.

and completion of group treatment (see Table 1). We therefore have information about the types of trauma exposures Petra had suffered, which included emotional neglect from both parents, having to look after parents or siblings, having parents with substance abuse or mental health challenges, emotional and physical abuse from a parent, and sexual abuse outside of family, all happening before the age of 15. Further details are not presented here due to confidentiality requirements.

The interviews were transcribed verbatim (word-for-word), including emotional tone, pauses, and so on. This resulted in rich data record, comprising 60 pages of transcribed material that formed the basis for our analysis, along with the time line and the information about trauma exposure from standardized questionnaires.

Methodological Approach

Data analysis were based on a hermeneutical–phenomenological approach (Alvesson & Sköldberg, 2000), allowing us to explore Petra's lived experience of recovery and how losing her husband influenced this process, while acknowledging the inevitable influence of interpretation in our understanding and presentation of Petra's story. In line with this approach, we believe that we are always bound by a context-dependent perspective, which influences the way we interpret and understand the emerging data and phenomenon of interest.

The meanings we derive from hermeneutical–phenomenological studies represent a *fusion* of our own and our participants' experiential *horizons*.

Both authors are psychologists with among others a humanistic orientation and we may therefore be disposed to trust the subjective perspective and the person's abilities to find inner strength and sense of agency to overcome difficulties. We have therefore stayed close to the data material, carefully tracking Petra's development from the first to the second interview, to ensure that our blind spots did not sway the research process. A dialogical view of reflexivity was central to the research process, and Petra's experiential horizon as expressed in the interviews was used actively to discover and reflect on our own preunderstandings and how these influenced the emerging research process (Alvesson & Skoldberg, 2000; Stige, Malterud, & Midtgarden, 2009).

Data Management and Analysis

NVivo 9 software (QSR International, 2010) was used as technical support for the analysis of the interview transcripts. Within the possibilities of the data material, we moved across and between different sources. Part of the analytic process was to structure the dataset from a chronological perspective, so that we could obtain an impression of Petra's experiences over time. We used Petra's time line (see Figure 1) to mark significant experiences in her life.

We initiated the analysis by reading through the transcripts several times to obtain a clear overview of the material. To create a condensed text of this case and the recovery process and thereby get a better overview, we produced memos with selected excerpts from significant themes in the interviews (Malterud, 2012). Through this process, we developed six analytical categories: contextual information, self-organization or distress experienced prior to the process of recovery, experiences with therapy, experience of recovery, understanding of husband in the light of his suicide, and Petra's self-awareness in the light of her husband's suicide. Following this initial organization of the data, we met and compared our analyses, reaching consensus on the categorization of the material. The first author then transferred this initial analysis into NVivo 9, and the authors then individually analyzed the material within each of our seven analytical categories, abstracting and condensing the core attributes of Petra's experiences within each analytical category. Finally, we compared the result of this secondary analysis, reaching consensus.

Based on this secondary analysis, we began working on constructing a coherent narrative, as expressed in the data material, of Petra's experiences related to the research question. Throughout the process, the authors met or had Skype meetings regularly to share their interpretations, to arrive at a consensus, and to agree on the next steps in the inquiry process. We followed the recommendations given by Hill et al. (2005) regarding consensual qualitative research with one exception, that is, we did not have an auditor who reviewed our understanding

of the material. An auditor would have been desirable to minimize potential *groupthink*. As the second author had no obligations in the overall research project, she took on the role of *devil's advocate*, especially with hypotheses regarding the potential role of the group trauma treatment on the participant's recovery process. We made a point of staying as close to Petra's own descriptions as possible. Material from both interviews was used in the complete analysis, and when Petra described the same topics or incidents on both occasions, we tried to enrich the descriptions or identify eventual changes in the manner she talked about it. Thus, the following is a narrative of the findings of this study, which are presented later. To emphasize the fact that the following is a result of our analysis and interpretation of Petra's experiences as she expressed them in the interviews, the narrative is presented in the third person, described from our perspective, but coupled with frequent quotes from the two interviews with Petra.

Findings

The findings will be organized by time, forming a *time line*. Through the analyses of the material, seven main themes emerged. These were titled: Early days; Detachment, turmoil, and full steam ahead; The rock; Therapy—Again?; Clearing skies; Lightning strikes; and Standing steady through the storm. Across these themes, the results are presented along two major trains of thought: traumatic experiences and the organization of the self.

Early Days

Petra grew up in a small town in rural Norway, in a strongly religious family. As described in her time line, she had some minor, PTE in her early childhood, but at that age she did not feel distressed about it. "I lived as a normal child," she explained. It was life as she knew it. When she talked about her childhood in retrospect, it gradually became clear that she was exposed to a wide range of PTE, including physical and emotional abuse, being witness to violence, and being separated from one of her parents. Through the dialog with her therapists and the other clients in the stabilization group, she gradually developed new perspectives regarding her own history and traumatic experiences. When reflecting back on her childhood now, she says:

I was shy, silent, and did not show any emotion. I had a stone face, but the fact was that I was very vulnerable (. . .) I now realize that there were many things that were not as they should be. I had a poor start in some fundamental areas of life.

As a grown up, she acquired a new understanding of her childhood. She was now able to understand emotionally that her experiences were beyond what

might be thought of as a *normal childhood* and could express more compassion for the child within.

Detachment, Turmoil, and Full Steam Ahead

The second theme encompasses how Petra lived her life in adolescence and early adulthood, organized around new traumatic experiences and her inner organization of self. In early adolescence, Petra experienced a major traumatic event that affected her tremendously:

It actually started when I was in my early teens... then something personally devastating happened... that has made me struggle. It has gone hand-in-hand with everything that has happened afterwards, I feel. It was a pretty huge thing that happened to me then.

In the aftermath of this, she became substantially more distressed (see Figure 1). Life became more unstable and she ran away from home, quit school, and started taking drugs. Emotionally she described herself with a strong inner tension, as if she was continuously going onward, pushing her limits, with no ability to pause. "I was constantly restless and anxious, living outside myself, with no focus, just moving forward without brakes." And she continued:

At the end... you feel, almost miserable. You feel like... "I can't choose anything, everything happens above my head, and I can't do anything about it. Things happen and happen and happen, and I can't control it. So, what kind of choice do I have?" You see?

At this age, she could not relate to her suffering. She repressed it and tried to move forward: "Because, I have had... been... repressed everything. I... Things have happened. I have repressed it and moved on. And I have been going on like that."

In her early 20s, she experienced another major trauma that lasted for some time. Now life was chaotic, she became depressed and her body collapsed. "Now I really started to have probl... personal problems." Because of the character of the trauma she was routinely referred to mental health services. "I tried some medications, I tried a bit... I was in psychotherapy, but I was not able to focus. My life was too chaotic. So it was really more like fire extinguishing at that time."

After a short period on sick leave she started to work again. She was impatient and eager to work. "I haven't had any brakes at all. I have only moved forward and... been ten horse heads in front of everything. That has actually exhausted me. Because... I haven't been able to stay calm enough to... focus and see things." In this period she began and quit therapy several times. When reflecting on her treatment experiences throughout her life, she described it as

if she was too unstable and anxious to profit from therapy at first. Her life was in too much upheaval. "I was in therapy, but it did not work, because I did not really go into myself. I was in therapy and talked, but I . . . I did not work with the internal stuff. I just talked."

The Rock

In this period of early adulthood, Petra met her husband. This represented a major shift in her life. Gradually, she managed to "take a step back, and take somewhat more care of myself." She described her husband as "a rock" in her life. With him, her life slowly started to stabilize. "After a few years, [with my husband], my life was stable, and then I felt this [recovery] process started." She dared to open up to him and to share her history and inner experiences. "I have spoken a lot to my husband. When we met, I talked for many years. He was a good listener; he has been like a psychologist for me, then, because . . . I talked about the same topics for many years." Through this process she gradually developed more self-compassion and confidence. In her relationship with her husband, she experienced a new feeling of safety and stability in her life that "opened new doors and made it possible for me to involve myself in psychotherapy."

Therapy—Again?

A few years ago, Petra's body collapsed once more, and she was unable to work. When describing this period, she said:

I had a lot of inner tension, and (sighs) hyperventilating, and this . . . restlessness. That was the worst thing. This restlessness in my body was overpowering. I could not control it. And the breathing, it was awful. It felt like I was suffocating (. . .) Lots of feelings that I'm not able to grasp. I have felt almost like being in a . . . I almost said . . . in a tumble dryer, and just being . . . Everything is messy and chaotic in my head, really. And very unstable . . . emotionally. Everything from being very energetic, really high, over-stimulated, or how I shall put it – not being able to calm down. To just wanting to sleep.

She was exhausted, had sleep disturbances, was not able to work, forgot things, had lots of bodily pain, and was scared of not being able to take care of herself. She decided to begin treatment again, even though her husband was skeptical:

He said: "why are you going to do that [start in therapy]? You only talk and talk!" But I felt that it was right, because now I felt that I could be open toward my feelings. That is why I started . . . I really believed in it when I started therapy, that now . . . I felt it, that I was ready to feel those emotions . . . not only talk about everything.

This decision also seemed to follow other personal achievements which strengthened her self-efficacy, like being able to give up smoking:

I could see that: "I did this!" I managed to quit smoking! And that is a big thing. I know a lot of people who can't do it. And then I had this moment where I knew there is actually some strength in me! And maybe I . . . Do you understand? So there is a lot that has happened through the years that has given me the confidence to approach this now and deal with the tough things.

She was motivated to begin therapeutic work. She contacted her general practitioner and was referred to the local outpatient clinic. This time her therapist and the general practitioner decided to keep her on sick leave for a longer period of time, which helped her to focus on treatment.

Clearing Skies

The fifth theme describes a gradual process of recovery. This process seemed to start a few years after she met her husband:

I feel that I started to change my way of thinking. Gained a bit more self-respect, saw a bit more of myself. In a way, I stood up for myself and all these things. I started earlier, some years back, starting to build a foundation on my own, really. Standing up for myself and listening to my needs.

Eventually Petra felt more serenity and stability in her life, and a sense that she could profit from therapy. She began individual treatment at the local outpatient clinic about a year before the trauma group treatment.

When reflecting back on her experiences with therapy in the posttherapy interviews, a major revelation was a sense of stability in her life and a feeling of inner strength. The constant restlessness and hyperventilating were gone. She now experienced increased bodily awareness, better control over her thoughts, a kind of ownership to her emotions, and more self-compassion, self-confidence, and vitality.

You are more aware, and manage to take your own needs more into account, and feel the body a bit more. "What is this?" And not least: "Is this dangerous? Is it something that I will have for the rest of my life?" You see? So a lot has made me feel very strong, because I am able to think. I feel that I am a bit more rational. I don't know. It is hard to explain. I just feel stronger! (strength in her voice). I do! [. . .] Before I began with the group, I was very unsure about: "What do I really want? What is best for me?" And I haven't known. But now I am very clear on what is best for me. I manage to see what is best for me. That I do what is best for me.

She also had a better understanding of her experiences and realized that her reactions were normal bodily responses to stress and trauma: “I have more calmness in my body when I have an explanation as to why I have these reactions.” Maybe the most fundamental change is a trust in her capacity to heal: “I have experienced that I have the strength and the necessary tools within. I have it all inside me!”

In the first interview she was, however, apprehensive as to whether she would manage to keep it up after the group therapy had ended:

Because, it helps a lot when you attend that group. Then there is a time afterwards. [...] So I think it can be scary, to suddenly be on your own again. [...] Because you have the symptoms attacking your body. And you go there [to the group] and you are reminded of how important it is to be in the here-and-now. [...] But if I get some help, you know, I might manage to use those tools and to stay focused. I can manage to heal myself.

Lightning Strikes

In the follow-up interview, 1 year after ending the stabilization group treatment, Petra shared that her husband committed suicide a few months after she completed the group. Now she had experienced a new, major trauma.

I thought that I would collapse after all this. And, you know . . . we had been together for many years, married for a long time, and (inhales) all the time I thought that he was my strength. I have felt that he was, in a way, my mountain cliff. He was my . . . he is the one I have leaned on and I felt that taught me everything.

After her husband's suicide, she gained a new understanding of him: “He struggled with the same things I have, only worse actually, because he hid it, locked it up inside. [...] Now I realize how weak he actually was.” The husband's suicide was a serious blow to the foundation Petra patiently constructed over the past years. Her understanding of her husband and herself in relation to him was seriously challenged. And at the same time she was deprived from her significant other—her rock, who offered her a sense of stability that made her process of recovery possible.

Standing Steady Through the Storm

The husband's suicide forced Petra to reconsider her understanding of herself:

Then I realized, especially after he was gone, that . . . oh my God, all this has existed within me. And I am the one who has been strong, while he has actually struggling

himself. It is actually me that helped him. So I am really shocked when I realize what is actually inside me.

Despite the tremendous inner turmoil following this traumatic experience, a strengthened sense of inner resources seemed to emerge. She was describing a strength and stability resting within, even in the face of new trauma:

It is as if it [the strength] has become a confidence now. It has never been that before. Because, the strength has been something I have been grasping for. I actually have strength, and hold on to that and focus on that.

Petra was also using her new understanding of her trauma history and trauma reactions as a resource in dealing with her own reactions following the husband's suicide:

I have had quite a number of traumatic experiences. Not just one, but many, one after the other. And to get the understanding of how the body reacts without being able to control it. [...] Then the things we learned in the group were incorporated about the brain and how the body reacts. Even though I did not consciously think about it, it was there at the back of my mind. That helped me not be scared when I was there, when I was in shock... In a way... out of yourself, you are almost psychotic, you are so deep down.

She was able to recognize both her sorrow and her strengths:

Yes, I am in a fundamentally different place now. Yes, because, I notice that after all that happened with my husband, then... even as early as four weeks after his death, I could say: "I feel strong". You know, I was so deep down, drowned in sorrow. I had so much sorrow that I just wanted to disappear. But at the same time I felt strength [...] the strength that I got when I was here [in treatment]. It did not disappear even when all this happened. The first week I felt that my whole world vanished. But gradually, after a few weeks, I could feel that the strength simply was there. [...] I have thought the opposite (laughs a little); I have thought... I realize now that I am standing very steady, even though he is gone. Even though it can be devastating sometimes, it is as if... I can feel the strength that rests within me. Not in him or in anybody else. And the importance of discovering one's self, or how shall I put it, to discover one's own strength.

And she continued:

When I ended the stabilization group, and this treatment, and everything, I felt like I was standing tall. Just like a tree that stands really steady. Even with all that has

happened to me now, nothing has made me topple. I have swayed a lot. But that is okay in a way.

She was able to recognize and utilize her own resources and at the same time accept and embrace the vulnerability and bereavement that follows an enormous loss like this. She was standing steady through the storm.

Researcher Perspective on the Two Interviews

In the two interviews with Petra, the interviewer perceived her as engaged, sincere, and highly motivated for the interviews. She was verbally strong and had a lot that she wanted to convey about her experiences with the stabilization group and her process of recovery. The interviewer did, however, experience a marked difference in the contact with Petra in the two interviews. In the first interview, there was a sense of nervousness and it was at times hard to follow her story, as she spoke rather quickly, and followed associations. She had clearly experienced important changes, but there was a sense of uncertainty as to whether she would be able to uphold this development without the stabilization group. In the second interview, the interviewer experienced her as calmer, more grounded, and more secure. She conveyed with strength and conviction a strong link between her experiences in the last year, and her continued process of recovery. Her presenting story of becoming secure of the availability and magnitude of her inner strength was reflected in the contact with the interviewer.

Discussion

The findings of this study suggest that persons that have been exposed to multiple traumas throughout life can progress in their recovery process when confronted with a new traumatic experience. In Petra's case, in the face of her husband's suicide she experienced an increased self-awareness, inner security, and strength. Her recovery process had been unfolding over many years prior to her husband's suicide. She had multiple treatment experiences, but it seemed that the relation to her husband was an important promoter for her to engage in and fully utilize the possibilities in the latest treatments. What seemed important to her in this process was a growing recognition of her own capability to recover, as well as knowledge about common psychological and bodily reactions after trauma.

So what may we learn from a narrative case like this? Petra's story illustrates how recovery from multiple traumas is a long and nonlinear path, and that new relationships and treatment experiences may provide a possibility for new and different paths when encountering a new trauma. Analyzing Petra's story, we see how a new traumatic experience may elicit processes and engagement in new possibilities in ways that consolidate an ongoing process of recovery, and potentially lead to further growth.

In a case study, it is not possible to discuss the outcomes of a study in relation to all of the theoretical and empirical sources that could be potentially relevant. In the following sections, the aim of our discussion is to offer some perspectives that invite the reader to consider the meaning and implications of the key themes that emerged from our analysis: recovery from multiple traumas and how a new traumatic experience potentially may consolidate the recovery process and lead to further growth.

Looking at Petra's history and earlier reactions to trauma, one interpretation of her current response to her husband's suicide could be that she reverted to an earlier coping style and minimized the impact of the trauma—just like she did when she was a child. This could be a kind of denial that is not unusual in the early aftermath of a traumatic event. However, as we, and herself, understand her process, there are several reasons to argue that she is now able to process and relate to the new trauma in a different way. In the following, we will promote these arguments.

Losing someone close in suicide is always a potential traumatic experience. Moreover, research and clinical experience suggest that the additive effect of multiple traumas places the person in an especially vulnerable position when confronted with new trauma, and that previous trauma experiences may trigger new trauma responses (Anda et al., 2006). Do we, then, have any reasons to believe that Petra's husband's suicide would place her in an especially vulnerable position as a consequence of her trauma history?

Possible triggers could be a history with loss of significant others. We do not have information on whether Petra had lost any close relationships before. Neither do we have information about Petra's attachment style, but we do know that she had a history of emotional neglect from both parents, as well as physical abuse from one of them, and that she through her relationship with her husband found a stability that she realized she had never had but always needed. In the interviews, Petra presents her relationship with her husband as a corrective emotional experience for her. He became a secure base in her adult life. It therefore seems that Petra looked at their relationship as well functioning, and that the husband's suicide was an unexpected disaster. In the literature, factors such as a well-functioning family life and the unexpectedness of the suicide are associated with greater difficulties (Clark, 2001).

Given the significance of the relationship between Petra and her husband and Petra's long history of traumatic exposure where each traumatic exposure was associated with increased experiences of distress (see Figure 1), one could expect that the husband's suicide would throw Petra off her feet. However, this did not happen. Her scores on the quantitative measures (see Table 1), Petra's own story, our interpretation of her story, and the interviewer's experience of the contact with Petra all point in a different direction—toward consolidation of recovery and growth.

Petra's process of developing a new self-understanding, getting more in touch with her own strength, and gaining the knowledge that her strength was a stable

and readily available resource, resemble processes described in the literature of PTG following sudden loss, with an increased sense of personal strength and increased self-efficacy (Davis et al., 2007; Tedeschi & Calhoun, 1996). She described how the ripple effects of losing her husband in suicide had made her sway, but she had not toppled. She was standing steady, fully in touch with her own strength and resources, as well as her sorrow and grief. But how should we understand that this trauma, and not the previous traumas, has triggered a process of growth?

Because of the significant role the husband had had in Petra's life and self-understanding, it seems reasonable to assume that his death seriously challenged her core assumptions. The experience thus has the element of seismic disruption believed to be significant in triggering PTG (Davis et al., 2007; Tedeschi & Calhoun, 1996). However, Petra had had a long history of traumatic exposure without signs of PTG. Rather, each traumatic exposure was associated with increased experiences of distress (see Figure 1), even though these experiences had challenged her assumptive world (see e.g., quotes on page 10). Then how come this traumatic exposure, losing her husband that had meant so much to her, triggered a process similar to PTG?

Petra's experiences of recovery prior to the husband's suicide were very much in line with existing research on the first-person's perspective on trauma recovery (Draucker et al., 2009; Harvey et al., 2000; Phillips & Daniluk, 2004). She experienced that the symptoms with which she had struggled with for years, the inner turmoil, instability, and difficulties in regulating affect and activity, had all improved substantially. She felt more in control of the situation, she understood what was happening to her and why, and she was more in touch with her own resources. In the first interview, she was optimistic, but also a bit apprehensive as to whether she would manage to continue these processes now that she had completed the group treatment.

One way of understanding the present findings is from the perspective of recovery—namely that Petra's process of recovery meant that she related differently to herself and hence had a different starting point for processing and coping with the husband's suicide than she had when exposed to earlier trauma. This might have made it possible for her to relate differently to this new traumatic experience. In the literature on growth after adversity, it is assumed that the person's ability to process the event, cognitively and emotionally, is a prerequisite for PTG (Siqueland & Hafstad, 2012) and that engagement with new possibilities is a mechanism for growth (Roepke & Seligman, 2015). One way to understand Petra's process following the husband's suicide is, therefore, that she managed to process this experience differently than previous traumas because she managed to stay in touch with her sorrow, weakness, and pain as well as her strength.

From a different perspective, it is interesting to discuss these differences in trauma-elicited processes at different points in Petra's life from the perspective

of SOC (Antonovsky, 1987). According to the theory, SOC is a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (a) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable, and explicable; (b) the resources are available to one to meet the demands posed by these stimuli; and (c) these demands are challenges, worthy of investment and engagement (Antonovsky, 1987, p. 19).

Relevant to our case, it is postulated, on a group level, that persons with a strong SOC in early adulthood will be able to maintain this position, while persons with moderate to weak SOC in early adulthood probably will get a weaker SOC over time (Antonovsky, 1987). This is significant because the strength of a person's SOC is believed to be related to the position on the health ease or disease continuum. For any given person, events that initiate considerable transformation of the level of the SOC can happen, but are considered unlikely. Moreover, it is not the events in themselves that lead to a change in SOC, but the way these events initiate new patterns of life experiences. If these new patterns are maintained over time, gradual change in SOC can occur (Antonovsky, 1987, p. 123).

It is interesting, then, to relate Petra's experience from the significant role her husband played in initiating her process of recovery to Antonovsky's postulation of how new patterns of life experiences over time can change the SOC. In her relationship with her husband, Petra found the stability she had always needed, but never had. She described how she gradually managed to take better care of herself, and her life became more stable. One way to understand Petra's ability to cope with her husband's suicide in such a different way than with previous traumas, then, is that her relationship with her husband and processes in therapy over time (i.e., both individual and group therapy) had led to a sufficiently strengthened SOC for her to be able to process the suicide both cognitively and emotionally (i.e., prerequisite for PTG). A strengthened SOC also seems to be reflected by the fact that she managed to mobilize and apply potential resources, including previous experiences with trauma-related problems, knowledge about trauma reactions, acquired skills, and therapist support to handle the situation.

This leads us to another important difference, we suggest. As part of her recovery process, Petra had gained a new understanding of her trauma history and trauma-related difficulties. Following the husband's suicide, she managed to draw from her previous traumatic experiences, previous experiences with posttraumatic reactions, and knowledge gained through trauma-focused treatment, using these experiences and knowledge as resources to understand her current reactions and guide her through her process. It was as if she perceived herself in a new position in relation to her husband. Through this, new opportunities emerged about whom she possibly could be and what resources rested within her. Her attribution of her experiences hence differed substantially from earlier, where her posttraumatic

responses made her wonder if she was going crazy and made her feel like she was the only one in the world struggling with such problems.

Rounding up loose ends, we see that Petra's process can be understood from different perspectives, but they all share the significance of being in touch with inner feelings, while at the same time managing to understand and making sense of one's own reactions, coupled with a sense of control and available resources. While the literature on PTG generally studies growth following single traumas, underlining the role of seismic disruptions to the assumptive world in triggering such growth (Davis et al., 2007; Tedeschi & Calhoun, 1996), what this case adds to the existing knowledge base is the possibility of growth also in persons who have been exposed to multiple traumas from early childhood and an example of possible mechanisms involved in such a transformation.

Strengths and Limitations of the Current Study

This is a case study, which allows us to focus on the phenomenon of interest in depth, to shed light on how experiencing a new trauma might influence the process of recovery from childhood trauma, and to explore possible processes and mechanisms at play. We cannot, however, generalize from this case to a larger population of trauma survivors. The strength of the case study is, however, to establish an example of how the phenomena of interest might present itself, paving the way for future research exploring the phenomena with different methodological approaches. Future research should explore larger samples of trauma survivors in a variety of settings, using both qualitative methods to explore the experience lived by trauma survivors, as well as quantitative studies exploring the relationship between processes of meaning making, trauma recovery, and resilience in the face of new trauma.

Conclusion

We believe that the findings of this case have important practical, as well as theoretical implications, in relation to understanding individual processes of change and recovery, as well as the timing of traumatic exposure in terms of understanding the potential consequences of new trauma. The case contributes to the literature by showing how persons with a history of multiple traumas without prior signs of PTG can experience PTG following new trauma exposure. The findings of this case elucidate how new significant relationships may foster new patterns of life experiences, which over time may facilitate recovery through a strengthened SOC. What seemed to be important mechanisms for growth after the latest traumatic exposure in the present case was the participant's ability to recognize and tolerate feelings, making sense of her own reactions, as well as a sense of control and available resources. More research is needed to explore the generalizability of these mechanisms.

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