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Pathways from Childhood Abuse to Positive Adaption: The Moderating Roles of Social Support and Coping Style

Abstract

Studies show that up to 50% of children worldwide are affected by physical, emotional, sexual abuse and/or neglect. While these traumatic events can have profound consequences on development across the lifespan, it is important to note that approximately 20-30% of childhood abuse survivors do not report negative impacts. One explanation for this difference in outcomes is the concept of resilience, defined as successful adaptation in spite of the experience of high-risk trauma. Many studies have been conducted to delineate factors fostering resilience. Some researchers argue that individuals' ability to achieve resilience is a direct result of the environment, while others feel individual characteristics play a strong role, and still others believe both are essential. The present study explored the roles that environmental protective factors, as assessed by social support, and internal resilience characteristics, assessed by coping style, play in buffering the relationship between childhood abuse and positive adaptation, assessed by life satisfaction, using hierarchical multiple regression.

It was hypothesized that both social support and coping style would significantly moderate the relationship between childhood abuse and life satisfaction, and that there would be a three-way interaction between social support and coping in moderating the relationship between childhood abuse and life satisfaction. Results indicated that adaptive coping styles (problem-focused and support-seeking coping) significantly buffered the negative relationship between childhood abuse and life satisfaction for survivors of childhood emotional abuse. Support-seeking coping also significantly buffered the negative relationship between childhood abuse and life satisfaction for all survivors of childhood abuse. Results are discussed in terms of understanding the mechanisms by which survivors can achieve positive adaption following childhood trauma.

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PATHWAYS FROM CHILDHOOD ABUSE TO POSITIVE ADAPTATION:
THE MODERATING ROLES OF SOCIAL SUPPORT AND COPING STYLE

A Dissertation

Presented to

the Faculty of the Morgridge College of Education

University of Denver

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Sarah Elizabeth Cleary

August 2016

Advisor: Patton O. Garriott, Ph.D.

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Chapter One: Introduction

International studies show that up to 25% of children around the world are affected by childhood sexual abuse (CSA), while 25-50% of all children report physical abuse (World Health Organization, 2010). Studies infer that approximately 10% of children are also exposed to emotional abuse, 10-15% to neglect, and 12% to witnessing domestic violence (Middlebrooks & Audage, 2008). The United States, as per the Child Abuse Prevention and Treatment Act (CAPTA), defines child abuse and neglect as: “Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm” (U.S. Department of Health and Human Services [USDHHS], 2015, p. 17). The prevention and intervention of child abuse occurs at the statewide level, and most states include physical, emotional, and sexual abuse, as well as neglect in their definition of child maltreatment. These events can occur in isolation, yet many children suffer multiple forms of abuse over time, resulting in complex trauma (USDHHS, 2015).

According to the most recent data from the National Child Abuse and Neglect Data System (NCANDS), approximately 3 million abuse reports were made to Child Protective Services (CPS) in the year 2013. 60.9% of reports were screened in (i.e., found to be at the level warranting investigation) and of these reports, 17.5% were found to be substantiated cases of abuse with 679,000 child victims indicated. The

victimization rate was significantly higher for children less than one year old (23.1% of child victims), highlighting the need for early intervention and prevention. 79.5% of all children in substantiated reports were victims of neglect, 18% were victims of physical abuse, 9% of sexual abuse, and 8.7% of psychological maltreatment (emotional abuse or neglect). 10% of these children experienced “other” types of maltreatment, which can include threatened abuse and parental substance use. In 2013, parents were the perpetrator in 91.4% of all substantiated cases. In 12.4% of cases, the perpetrator was not a parent, but the largest categories were male relatives or caretakers, and male partners of children’s parents (USDHHS, 2015).

Even given these high rates of incidence, there is also much evidence suggesting that the numbers may not be as accurate as one would hope. Many children never disclose maltreatment due to issues of shame, fear and isolation, especially in cases of childhood sexual abuse (Pereda, Guilera, Forns, & Gomez-Benito, 2009). Additionally, many cases of childhood abuse are often incorrectly accredited to accidental causes, such as falls, burns and drowning (World Health Organization, 2010).

Consequences of Childhood Abuse

Consequences of childhood maltreatment include potential impairment to physical, mental and social health throughout the lifespan (World Health Organization, 2010). Physical consequences of abuse, such as damage to a growing brain, can have permanent implications in terms of cognitive delays and/or emotional difficulties (Child Welfare Information Gateway, 2008). In extreme cases, child abuse and neglect can even result in the death of a child. In 2013, there were an estimated 1,520 child fatalities from abuse and maltreatment; approximately two-thirds of which were attributed to neglect,

another one-third to physical abuse exclusively or in combination with other maltreatment types (USDHHS, 2015).

In some cases, childhood abuse (CA) can be an etiological factor in the development of psychological disorders (Linden & Zehner, 2007). Psychological consequences are indeed the most common side effects for victims, and may lead to increased susceptibility for low self-esteem, depression, anxiety, posttraumatic stress disorder (PTSD), eating disorders, obesity, suicidality, self-harm, revictimization, and increased high-risk behaviors throughout the lifespan (e.g. substance abuse, risky sexual activity, violence and criminal behavior, and repeating the cycle of violence through abuse perpetration) (Child Welfare Information Gateway, 2008; Molnar, Berkman & Buka, 2001; Swanston et al, 2003; World Health Organization, 2010; Middlebrooks & Audage, 2008). Clients with co-occurring mental illnesses and substance abuse problems are also more likely to be victims of childhood trauma, with exposure rates ranging from 48% to 90% (Weissbecker & Clark, 2007).

Positive Adaptations

Although there is a link between CA and negative outcomes, it is also important to note that approximately 20-30% of survivors do not report psychological distress as a result of childhood maltreatment (Child Welfare Information Gateway, 2008; Hilton & Mezey, 1996). One potential explanation for this difference in outcome has been described in the literature as resilience. Resilience is a complex, subjective term and as such, definitions vary considerably across studies. Some researchers have raised the question of whether resilience should be seen more as positive functioning arising from

negative situations or simply competent functioning performed under ongoing stress (McClure, Chavez, Agars, Peacock & Matosian, 2008).

Researchers have organized resilient individuals into three potentially distinguishable groups: those experiencing exemplary outcomes following adversity, those displaying positive but not exceptional development after adverse experiences, and those who eventually experience adaptive functioning after initially suffering negative consequences (Banyard & Williams, 2007; Masten, Best & Garmezy, 1990). One study examining resilience as a construct determined that resilience does contribute to the variance in individual outcomes significantly over and above the mere absence of vulnerability and psychopathology (Friborg, Hjemdal, Martinussen & Rosenvinge, 2009).

The definition of resilience to be considered in this study is consistent with the work of Masten and colleagues (2009), referring to an individual's ability to achieve "positive adaptation in the context of significant challenges," or to develop successfully during or following exposure to adversity or risk, wherein the risk infers the elevated probability of negative outcome (Masten, Cutuli, Herbers & Reed, 2009, p. 119). Definition of positive adaptation also varies, in that it can be viewed as internal (psychological well-being, happiness and life satisfaction vs. emotional distress) and/or external (achievement of developmental tasks and academic/occupational success vs. criminal or risk-taking behaviors) (Masten et al, 2009).

These themes connect well with behavioral and personality factors discussed later in this chapter, in terms of their contribution to how resilience varies across individuals. Many studies have been conducted to delineate factors that promote resilience. Some researchers argue that individuals' ability to achieve resilience is a direct result of the

environment, while others feel that genetic or person-based characteristics play a strong role – the classic nature vs. nurture debate. Perhaps the best argument is one in which the interaction of both genes and the environment (G x E) influence individual adaptation (Rutter, 2013).

Assets and protective factors.

Much research has concerned what environmental elements contribute to greater resilience and better adaptation in individuals, with a particular focus on external social supports. Within the resilience research, the term “asset” refers to factors that are predictive of positive outcomes across all levels of risk, whereas protective factors are specifically advantageous to those experiencing a high level of adversity (Masten et al, 2009). For example, the presence of strong social support systems is helpful for all individuals, yet these systems have been found to be particularly useful in the positive adaptation of adult survivors of CA. Research has shown that the earlier CA survivors have social supports in place, the more likely they are to build upon and sustain their resilience throughout the lifespan by continuing to develop new, ongoing supports for subsequent challenges (DuMont, Widom & Czaja, 2007).

Perception of spousal or partner support has been found to lead to fewer symptoms of depression, and to be significantly associated with higher perceived levels of physical health in CA survivors (Wright, Fopma-Loy, & Fischer, 2005). DuMont et al (2007) corroborated this finding in a study that showed CA survivors with a supportive partner or spouse were almost twice as likely as those without to exhibit resilience in young adulthood. The onset of mentoring or caretaking roles in relationships with vulnerable others, such as children or pets, has also been found to be particularly valuable

in the rebuilding of relational trust and resilience, especially for male survivors of abuse (Kia-Keating, Sorsoli, & Grossman, 2010).

Family characteristics can be of vital importance in predicting long-term resilience among CA survivors. While family conflict and parental negativity can exacerbate the impact of CA, family cohesion, stability and positive functioning can reduce psychological distress by enhancing individuals' self-esteem and promoting feelings of self-competence (McClure et al, 2008). However, this can be complicated, as most CA has been found to occur within the home at the hands of parents or other caretakers (USDHHS, 2015).

Thus, the addition of support from outside the home can be particularly salient. The presence of positive relationships from childhood through adulthood has been correlated with positive outcomes over time after the occurrence of childhood abuse, highlighting the need for a lifespan perspective when considering positive adaptations following adversity (Rutter, 2007). Survivors who had a close relationship with a mentor or other supportive adult figure were found to be more resilient, and have better chances for positive outcomes and adjustment later in life (McClure et al, 2008). A sense or belief of acceptance, or belonging to a group can contribute positively to resilience (Simpson, 2010). Positive peer influence, religious beliefs, and academic mastery were also found to be helpful (Edmond, Auslander, Elze & Bowland, 2006). Additionally, neighborhood cohesion and sense of community have been found to have a small effect on CA survivor adaptation (Jaffee, Caspi, Moffitt, Polo-Thomas & Taylor, 2007).

Individual factors.

While less information is known about this area, it appears that biological/genetic factors, such as individual personality and behavioral tendencies, have been shown to influence resilience as well. Some proponents of the idea that protective factors lead to resilience feel that individual factors are better viewed as outcomes of adjustment resulting from resilience. Yet, other researchers feel that these individual characteristics should be conceptualized as variables that contribute to the process by which survivors achieve positive adaptation (Lam & Grossman, 1997). The present study agrees with the latter viewpoint in that both protective factors and individual factors may play important roles in buffering the relationship between early childhood adversity and positive outcome (Masten et al, 2009).

A recent review of resilience studies in the childhood maltreatment literature revealed that researchers use a variety of characteristics to determine whether or not individuals are resilient, and thereby have achieved positive adaptation. Examples of resilient behavior assessed ranged from lack of problem behavior, graduating from high school, and absence of a diagnosed mental health disorder, substance use disorder, or delinquent behavior. Although these studies have helped to shed light on what qualities constitute resilient individuals, the wide range of measurements used has made generalizability of results difficult, and more information is still needed on how to best operationalize resilience in individuals (Klika & Herrenkohl, 2013).

Rutter (2007, p. 205) proposed the idea that resilience studies on CA survivors shift from a focus on risk and protective factors and “variables” contributing to positive adaptation (i.e., external development), to a study of the “processes or mechanisms” by

which individuals may also achieve resilience (i.e., internal development). Rutter calls for greater attention to G x E interaction in studies, with a particular focus on the aspect of coping style and its contribution to resilience. The process by which individuals deal with upsetting life events and other challenges may play an important role in explaining differences in survivor outcomes. Rutter hypothesizes that individuals exhibiting positive coping behaviors would be more likely to experience resilience (Rutter, 2007). Similarly, Wright and colleagues found that use of avoidant coping strategies was strongly and consistently associated with negative resilience outcomes (Wright et al, 2005).

Related to style of coping, qualities such as internal locus of control and low self-destructiveness have also been identified as significantly contributing to personal resilience (Wright et al, 2005). Gust (2000) noted the importance of internal locus of control and its relation specifically to resilience in CSA survivors' ability to overcome feelings of powerlessness and shame relating to the abuse, and to reframe those events in a more empowering context. McClure et al (2008) found that an individual's ability to positively reframe events or have an optimistic outlook was similarly related to resilience in survivors: "when stressful events do not overwhelm the ability to cope, the victory over adversity enhances a sense of self-competence" (McClure et al, 2008, p. 86). A sense of future orientation, specifically related to educational or vocational goals or plans, was also found to be helpful in increasing likelihood of resilience following early childhood trauma (Edmond et al, 2006). The ability to engage in planning, having a sense of agency, and self-reflection are intrinsic characteristics that may also be linked to the process of resilience (Rutter, 2013).

Other individual factors identified as influencing levels of resilience outcomes include high control against deviant behavior and the ability to work well with others (Simpson, 2010). High self-control has also been linked to better ability to cope with adverse events, as well as greater positive health outcomes (Boals, vanDellen & Banks, 2011). Neither high IQ nor gender has been found to have an impact on positive adaptation following CA (Rutter, 2007). In one study, resilience was associated with less loneliness, greater hopefulness, increased feelings of self-reliance, and the engagement in fewer life threatening behaviors. Interestingly though, this also resulted in greater interpersonal disconnectedness (Rew, Taylor-Seehafer, Thomas & Yockey, 2001).

The Dandelion and the Orchid

Although it is clear that protective factors are important aspects of resilience, it is still unclear to what extent resilience may be inherent to individuals and separate, over and above the presence of protective factors, in predicting survivor outcomes. Boyce & Ellis (2005) present the idea of Biological Sensitivity to Context (BSC), also known as “The Dandelion and the Orchid,” wherein the possibility exists that some individuals may be predisposed to adaptive competence in both highly stressful and highly protective environments (Boyce & Ellis, 2005).

According to the theory, highly reactive and sensitive children (i.e., the Orchids) seem to obtain the best or worst outcomes depending upon their context. Orchid children are highly sensitive to conditions of adversity, resulting in overall higher rates of physiological and psychological distress than the average peer. Yet in positive and low stress environments, they are less susceptible to health, behavioral and emotional disorders than their less reactive peers (Boyce & Ellis, 2005). On the other hand, the

nonreactive “dandelion children” seem to have the capacity to get by, and even excel, in whatever environments they encounter “much the same way that dandelions seem to prosper irrespective of soil, sun, drought, or rain” (Boyce & Ellis, 2005, p. 283-284). Accordingly, the authors write that observations of this phenomenon have inspired much discussion throughout the resilience literature, in wondering whether the capacity for positive adaptation in spite of adversity is truly environmentally based, or rather, if it is innate (Boyce & Ellis, 2005).

Study Rationale

This study seeks to describe the mechanisms by which both environmental and individual factors promote resilience, thereby leading to positive adaptation. When considering the Dandelion and Orchid theory, one would conceptualize that some individuals are inherently resilient, and do not need protective factors in order to achieve positive adaptations following a high-risk trauma (Boyce & Ellis, 2005). Alternately, it could be theorized that since environmental protective factors are a major component of what researchers have suggested leads to resilient outcomes, individuals’ ability to access these external supports may be sufficient in order to attain positive functioning (Luthar et al, 2000). Further, others would argue that both are necessary, highlighting the importance of person-environment interactions in the resilience debate (Rutter, 2013). Based upon the overarching theory and literature presented, the present study hypothesizes that the relationship between childhood abuse and positive adaptation depends on both social support (i.e., protective factors) and individual coping style (i.e., individual factors).

According to Masten et al (2009), investigators wishing to study resilience phenomena must define the criteria for identifying positive adaptation (i.e., life satisfaction) as well as the presence of conditions, either past or current, that would threaten to disrupt developmental processes (i.e., childhood abuse). The authors suggest that moderating effects can be examined through the lens of protective factors, as well as risk-activated protective factors. Whereas general protective factors exist regardless of the presence of trauma, they are even more helpful to those who have experienced an adverse event. Meanwhile, risk-activated protective factors are internal assets that turn on specifically in the presence of high-risk events. In this case, level of social support acts as a protective factor, buffering the relationship between childhood abuse and positive adaptation; whereas an individual's ability to utilize positive coping skills would be an internal resilience characteristic and risk-activated protective factor. The purpose of this method is to better understand how early childhood threats can impact developmental processes over time, in the hopes of shedding greater light on potential predictors of survivors' outcomes following childhood maltreatment (Masten et al, 2009).

The Present Study

The present study will test Masten's (2009) theoretical model of resilience, wherein protective factors (as represented by social support) and individual factors (coping style) moderate the relationship between childhood abuse and positive adaptation (life satisfaction). Hypotheses for the present study are:

1. After controlling for participant age, education and income, social support will moderate the relationship between childhood abuse and life satisfaction.

2. After controlling for participant age, education and income, coping style will moderate the relationship between childhood abuse and life satisfaction.
3. There will be a three-way interaction between social support, coping style and childhood abuse in predicting life satisfaction.

Chapter Two: Review of Literature

The purpose of this chapter is to present a history of the topic, in terms of how childhood abuse has been viewed and studied over time, as well as the theoretical and conceptual development of the ideas of resilience and protective factors, and their importance in the childhood trauma literature. Various schools of thought on these topics will be presented in terms of how these views impact the present study.

Early History of Childhood Abuse

In the era prior to 1875, there was not much in the way of laws or societal regulations to protect children from abuse and maltreatment (Myers, 2011). In fact, child abuse was a rather common practice in many early societies, referred to as “humanity’s most powerful and most successful ritual,” and a “nightmare from which we have only recently begun to awaken” (deMause, 1998). Historical accounts include customs of incest, genital mutilation, child sacrifice, beating and neglect. Violent beatings were a regular part of children’s lives, and records indicate many implements for inflicting bodily harm (e.g., cat-o’-nine tails, iron rods, the flapper – used by schools to create blisters, the discipline – a whip made of small chains, etc.). Traditionally, young girls were often married off to older men, a practice that would nowadays be viewed as statutory rape. In Ancient Greece and the Middle Ages, sexual abuse of young children was widespread. In some cases, rape was even seen as a viable cure for depression:

“Raping virgins was particularly effective for impotence and depression, as one medical book put it” (deMause, 1998).

During the 17th and 18th centuries, the societal movement turned less toward acting upon children and neglect became more prevalent. Instead of beating children, it became more common to lock them up in dark closets, sometimes for days at a time. As the 19th century began, parents took more to sending their children out into the world to “be socialized,” which often resulted in other caretakers taking advantage of or inflicting abuse upon the children (deMause, 1998). However, despite this, some small progressions toward the recognition of child maltreatment were being made. In 1856, the first rape conviction in history, *People v. Benson*, reached the California Supreme Court. The victim was a 13 year-old girl (Myers, 2011). In 1869, *Pletcher v. People*, the Illinois Supreme Court disagreed that parents have sovereign right to discipline their children as they see fit, writing instead that “parental authority must be exercised within the bounds of reason and humanity” (Myers, 2011, p. 4).

In 1874, the case of Mary Ellen Wilson, a neglected young girl living in the Hell’s Kitchen neighborhood of New York City, provoked missionary Etta Wheeler to embark upon a quest to rescue and remove the girl from her abusive caretakers. To do so, Wheeler enlisted the help of Elbridge Gerry, the then head of the American Society for the Prevention of Cruelty to Animals (ASPCA). In realization that society had a system in place to protect animals, but no such safeguard for human children, the New York Society for the Prevention of Cruelty to Children (NYSPCC) was established in 1875. This event marks an important step in the recognition of abuse as an issue, and toward the

prevention of children from maltreatment. Through this realization, it became apparent that more formal training was needed to assist victims of abuse and neglect. In 1898, the New York School for Philanthropy (which would later become the School of Social Work at Columbia University) was created to begin training professional social workers to assist in matters of child welfare and mental health (Myers, 2011).

The role of Freud.

Around the same time that child abuse was beginning to be recognized as a significant issue within society, Sigmund Freud was beginning to develop his own ideas about trauma and the etiology of mental illness from early childhood experiences, especially relating to sexual abuse and sexuality. Freud hypothesized that early childhood experiences have a significant impact on later adult development and behavior, a vast breakthrough in the study of the human mind (Corey, 2009). Around this time, many female patients seen by Freud and his colleagues were presenting with a disorder at the time labeled “Hysteria,” which was often comprised of “convulsions” (i.e., panic attacks), vomiting, audio/visual hallucinations, being in a “dream-like state” (i.e., dissociation), repression of traumatic memories, suicidal or homicidal ideation, self-harming behaviors, and sexual acting out behaviors (Emerson, 1913, p. 181, 182).

Freud felt that Hysteria was caused by “occurrences of premature sexual experience,” and the repression of such, and determined to work with patients dealing with the disorder (McOmber, 1996, p. 343). He hypothesized that the hysterical symptom was a result of two opposing forces within an individual – one striving to bring realization to the abuse experiences, and the other trying to extinguish them. Although of

particular relevance to sexual trauma, this theory could be applied to any form of early childhood abuse. Repression of trauma was often thought to lead to the separation of the mind into independent parts, called “Dissociation of Consciousness,” likely an earlier form of today’s Dissociative Identity Disorder (Emerson, 1913, p. 181). Additionally, Hysteria was referred to as “essentially a disease of personality,” also likening to today’s Histrionic or Borderline Personality Disorders, which are often indicated in cases of complex trauma and abuse (Emerson, 1913, p. 206).

Criticisms of Freud. For all of those who lauded Freud’s work, there were many at the time that also denounced him. One author criticized that Freud’s psychoanalytic work was unscientific in nature and failed to show a “causal relationship” between emotional disturbance and sexual trauma (Kirby, 1908, p. 268). Another felt that although Freud did have a point about early childhood’s role in informing later development, sexuality and the connotation of sexuality was simply over-written and over-interpreted into far too many experiences. The author felt that Freudian interpretations were subjective by nature, and not actually based upon fact. For example, the statement “her dreaming that the man put his hand in her pocket requires no analysis. The pocket is a frequent dream-symbol for the vagina” was felt to exemplify this sort of subjective interpretation (Haberman, 1914, p. 269). Other psychologists at the time criticized that “psychoanalysis resolves itself into a searching and filthy examination into the past sexual life” (Haberman, 1914, p. 266). Even supporters of Freud noted the limitations of his methodologies, stating that the “doctrine of symbols seems to have been

one of the worst stumbling-blocks to a more general acceptance of Freudian psychology” (Emerson, 1913, p. 192).

Later, Freud would retract some of his earlier assertions, reporting that he began to doubt the overall truthfulness of many of his female patients’ recalled stories of sexual abuse, as they frequently involved their fathers. He thus hypothesized that perhaps the stories were not factual, but moreover, fantasies resulting from unresolved issues of the Oedipal complex. These revocations of his earlier groundbreaking theories implanted seeds of doubt into the already controversial topic of early childhood abuse, thereby providing an excuse for forthcoming generations to deny the existence of sexual abuse as a phenomenon deserving of serious attention, and later paving the way for controversies involving repressed and recollected memories of CSA (McOmber, 1996).

20th Century: Childhood Abuse as a Focus of Study

Moving into the 20th century, the issue of child abuse as a national problem in need of remedy began to gain momentum within the U.S., yet progress was still slow. In 1912, the Children’s Bureau was created as the first federal agency to oversee the welfare and well being of children. Prior to this, child protection had been handled predominantly by charitable organizations, such as the NYSPCC. By 1922, there were over 300 non-governmental protection agencies spread across the country, yet it was still not enough. However, as the Great Depression began, funds available for philanthropic causes began to wane. In 1935, Present Franklin D. Roosevelt brought light to these problems by proposing the Social Security Act as part of the New Deal, created to provide monetary assistance to struggling families for the purpose of child welfare and

protection (Myers, 2011). Today, the Social Security Act, Titles IV-E and IV-B, are still the main sources of federal funding used to provide child welfare and protection (American Humane Society, 2013c).

It was not until the 1930s that any of Freud's ideas were tested with research (Gagnon, 1968). Dr. John Caffey, a pediatric radiologist, hinted about the possibility of child abuse in his classic 1946 paper, which began to illuminate the issue of child abuse as a prevalent and serious problem (Myers, 2011). However, there were still many messages within the research community that downplayed the severity and nature of child sexual abuse. Several studies in the early to mid-1900s posited that in cases of CSA, the children involved were "unusually attractive and charming," and even went so far as to suggest the child as the seducer of the adult (Gagnon, 1965, p. 185). This brings up the debate of children's behavior, and whether or not children can actually consent to or know what they are consenting to in regard to sexual situations; an idea that is still hotly contested (Tromovitch & Rind, 2007).

At that time, there were also many questions about the truthfulness of children's stories of abuse, particularly concerning those involving CSA, and whether they were just that – "stories." It was a common practice by investigators to make use of "suggestibility tests" in order to verify accusations of CSA. If children were seen as avoidant of the subject or distractible, then they were less likely to be believed (Trankell, 1958, p. 389). However, today we know that avoidant behaviors and decreased concentration are actually both signs of PTSD resulting from a traumatic event (American Psychiatric Association, 2013). The judgment of incidents of abuse as possibly false, disbelief of

victims' accounts of instances of abuse, accusations that child victims perpetrated the abuse, and studies reporting lack of negative outcomes for abuse survivors led to CSA becoming a more taboo subject (Gagnon, 1965).

The need for regulation.

Other than Dr. Caffey's article, the idea that child injuries could actually be intentionally inflicted, and oftentimes by parents nonetheless, did not emerge in the medical community until around 1955. Prior to that, there was a general failure of physicians to report these injuries, as there were no regulations in place holding them accountable, or an official protocol if they wanted to file a report. In 1962, Dr. Henry Kempe introduced his publication "The Battered-Child Syndrome," which was to become a hallmark paper in the recognition of child abuse (Schloesser, 1964). Kempe also made the important assertion that many parents who perpetrate abuse are themselves victims of childhood abuse by their parents or caregivers, thus introducing the classic cycle of violence idea in child abuse and coining the phrase "Do unto others as you have been done by" (Schloesser, 1964, p. 267).

This sparked the beginning of media interest in child abuse (Myers, 2011). Finally recognizing the widespread issue, the Children's Bureau held a conference that same year to start discussing what supports needed to be put in place to prevent against and assist victims of childhood abuse (Schloesser, 1964). In 1963, the Bureau drafted a "model law" for physician reporting; by 1967, nearly all states had laws in place for child abuse and reporting, but there was not enough funding to provide adequate child protection to everyone (Myers, 2011). In 1972, the Kempe Center was established at

University of Colorado Hospital to “provide research, training, education and innovative program development for all forms of child abuse and neglect” (Kempe Center, 2013, p. 1). With the help of U.S. Senator Walter Mondale, Congress took a lead role in helping to pass the Child Abuse Prevention and Treatment Act of 1974 (CAPTA), to “improve the state response to physical abuse, neglect, and sexual abuse,” by supporting increased investigation and reporting procedures, as well as training for professional responders (Myers, 2011, p. 11). By 1976, all professionals were finally instituted as mandated reporters for child abuse (Myers, 2011).

However, it was not until 1977, in Dr. Kempe’s noteworthy speech, “Sexual Abuse, Another Hidden Pediatric Problem,” that CSA was officially incorporated into the child abuse spectrum, bringing true light to sexual abuse as a pervasive problem (Mrazek, 2013). In Finkelhor’s 1979 study, he noted that the child abuse field was finally shifting from a focus on physical injury and neglect to that of the sexual exploitation of children. By 1980, the federal government passed the Adoption Assistance and Child Welfare Act, to help states create permanency plans for those children removed from their home environments (Myers, 2011). That same year, PTSD as a diagnosis was added to the Diagnostic and Statistical Manual of Mental Disorders (DSM), highlighting the need for trauma-focused treatments (Jaffe, 2012).

In 1982, Dr. Kempe wrote an article on changing the perspectives on treatment for child abuse and neglect, and how traditional ideas of treating the family (focus was on the mother, with little focus on the father or child victims themselves) could no longer be viewed as sufficient. Kempe recognized that parents needed support groups to

adequately meet their child's needs following recovery from the abuse, but emphasized that the child victims needed to become the true focus of treatment. At the time, one possible option noted was the use of therapeutic day nurseries, but he underscored that a call for a greater variety of viable and tested interventions was also needed (Kempe, 1982).

Continued controversy.

With the increased visibility and media representation of child maltreatment, and particularly CSA, many survivors began to share their stories. Hearing about other victims' stories, individuals may have become triggered, and began to discuss painful memories that they had dissociated over time. Of course, this in turn sparked the "false memory" controversies in the 1980s and 1990s, which led back to more disbelief and shunning of victims' stories (Williams, 1996, p. 207). Critics of the idea of "repressed memories" of CSA developed the idea that false memories of abuse could be implanted by leading questions or suggestions made by therapists (Dammeyer, Nightingale & McCoy, 1997, p. 252). Many people commented whether repressed memories were even real, or if such a thing could exist (Dammeyer et al, 1997). Meanwhile, others posited that research suggests little to no empirical evidence of such a false memory syndrome (Williams, 1996).

In their 1997 article, Rind & Tromovitch argued that there is only a small association linking CSA to negative psychological outcomes in the general population, and that there is no proof that CSA causes adverse adaptations, but that they merely share a small correlation (Rind & Tromovitch, 1997). Most controversial beyond this was the

article's assertion that in some instances, the abuse experience had actually been deemed as positive and sometimes consensual, and should therefore instead be labeled "adult-child sex" (Lillienfeld, 2002, p. 177). However, proponents of the authors' statements cautioned that the absence of harm did not necessarily imply lack of wrongdoing, although the presence of wrongdoing did not automatically imply harmfulness either. The Rind & Tromovitch articles sparked much criticism, both from the American Psychological Association, and from other researchers, therapists, and victims' advocates within the field of psychology (Lillienfeld, 2002).

Although it is generally accepted within the field that the occurrence of both CA and CSA do pose negative consequences to victims, Rind & Tromovitch continue to posit that the damage incurred as a result of CA is minimal, and therefore not warranted for further study (Tromovitch & Rind, 2007). These assertions expose the construct of CA and its impact on psychological functioning to continued issues of doubt and minimization. Even in light of how far the study of child abuse has come, these controversies highlight the need for more research examining the ramifications of CA on survivor adaptation, as well as what factors play a role in protecting victims against adverse outcomes.

Definitions and Impact by Abuse Group

Research indicates that although there are some distinctions in survivor outcome by type of abuse experienced, there are greater similarities than differences (Mullen, Martin, Anderson, Romans & Herbison, 1996). Additionally, because many traumas occur concurrently, it can be difficult to parse out which effects result from which abuse

types (USDHHS, 2015). However, it is still important to examine what known similarities and differences in outcome exist between sexual, physical, emotional abuse, and emotional and physical neglect, the abuse criteria to be examined in the present study. This section will also include a clear description of each child maltreatment type to be studied, to provide clarity.

Childhood sexual abuse.

Definition of childhood sexual abuse. When examining the impact of childhood sexual abuse, it is important to have a clear description of what is being discussed, although much controversy still exists in terms of what criteria should be used for inclusion. Some researchers have defined CSA as having occurred before the cutoff age of 18, whereas others have used cutoffs below or above that. Incontrovertibly, this has led to variability in the reported prevalence of CSA from any given sample. Discrepancies also exist in what constitutes sexual abuse itself. The common and preferred definition for CSA is typically seen as “contact or non-contact sexual experiences between a person under 18 years of age and an adult or other person at least 5 years older; or sexual experiences resulting from coercion, no matter what the age of the other person,” as recommended in Finkelhor’s classic (1984) proposal (Pereda et al, 2009).

Impact of childhood sexual abuse. Individuals experiencing CSA have been found to be more likely to also experience other forms of childhood maltreatment, citing that the impact can be particularly damaging for these victims (Middlebrooks & Audage, 2008). According to the National Comorbidity Survey, the lifetime prevalence of

depression is higher in CSA survivors (39.3%) than in the general population (21.3%) (Molnar, Buka & Kessler, 2001). Higher rates of depression have been echoed in numerous other studies on CSA survivors as well (Browne & Finkelhor, 1986). Hopelessness was found to be a particularly salient mediating characteristic between CSA and suicide attempts for both male and female survivors, more so than the general population of attempters (Stokas, Wenzel, Stirman, Brown & Beck, 2009). Additionally, CSA survivors have been found to be at higher risk for suicidal ideation and attempts (Stokas et al, 2009; Browne & Finkelhor, 1986).

Victims of CSA are also more likely to experience damage to their sense of self (Mullen et al, 1996), encounter attachment and trust issues, difficulties with interpersonal relationships, and intimacy and/or sexuality problems, which may lead to increased psychological distress and psychopathology (Dimitrova et al, 2010), and specifically, higher levels of PTSD symptomology (Bedi, Muller & Thornback, 2013). They may be more likely to become pregnant before the age of 19, to not graduate from high school, and to be of lower socioeconomic status (Mullen et al, 1996). Although females are more likely than males to experience CSA, males are also at risk, and a strong relationship has been found between CSA and psychopathology in both sexes (Molnar, Buka & Kessler, 2001; Putman, 2003).

Child physical abuse.

Definition of child physical abuse. Child physical abuse (PA) can be defined as “non-accidental trauma or physical injury” in the form of beating, kicking, hitting, burning or otherwise acting upon a child in order to inflict harm (American Humane

Association, 2013a). While PA can be the most visible form of child abuse, it still can often go undetected. In many situations, PA occurs as a result of caretakers' excessive disciplinary strategies, lack of parenting skills and feelings of isolation; however in some circumstances, other issues such as parental alcohol/drug abuse and/or domestic violence may play a role. Many parents or caregivers may also be unaware of the impact their force has upon children's developing bodies, especially when reacting in anger (American Humane Association, 2013a).

Impact of child physical abuse. Research demonstrates that adolescents who have experienced physical abuse tend to be at higher risk for behavioral issues, depression, delinquency, and high-risk behaviors than those who do not experience PA (Miller & Salzinger, 2008). Adult victims experiencing PA in childhood may be more likely to experience marital problems ending in divorce or separation, sexual problems, and higher likelihood of mental health problems, particularly depression (Mullen et al, 1996). Additionally, aggression toward others appears to be a main feature present in victims of PA, over and above that seen in survivors of other abuse types. This finding makes sense in that children's observation of adults in their environment often leads to modeling of those behaviors later in life (Briere & Runtz, 1990).

Another interesting finding includes the common occurrence of both physical and emotional abuse in childhood (Briere & Runtz, 1990). When paired with high levels of verbal aggression, high incidence of physical aggression within the home environment was also likely to be reported by survivors (Mullen et al, 1996). The simultaneous experience of both physical and emotional abuse during childhood has been found to

result in later difficulties in each of the following realms – chronically low self-esteem, sexual behavior issues, and anger management problems (Briere & Runtz, 1990).

Child emotional abuse.

Definition of child emotional abuse. Emotional abuse (EA), also referred to as psychological maltreatment, has long been one of the most difficult terms to define and operationalize, and therefore also one of the most difficult abuse types to detect and substantiate (Moeller, Bachman & Moeller, 1993). EA appears to be described by the following characteristics: “chronic denigration of a child’s qualities, capacities, desires;” isolation; threats; “subjecting a child to excessive age-inappropriate demands;” and repeated exposure to severe domestic violence (Moeller et al, 1993, p. 625). The American Humane Association also includes failure on the part of the caretaker to actively be present for a child, refusal to respond to a child’s needs, and exploiting or corrupting a child in their working definition of childhood emotional abuse (American Humane Association, 2013b).

Impact of child emotional abuse. Adult victims experiencing EA in childhood may be at higher risk for experiencing dysfunctional eating behaviors, to have been hospitalized on a psychiatric inpatient unit, and to regard their current partner as uncaring or overly controlling. Interestingly, survivors of childhood emotional abuse have been found to have significantly lower self-esteem than survivors of other abuse forms (Mullen et al, 1996). Characteristics particular to this group include intense feelings of self-criticism, a sense of guilt, and feeling that they are undeserving or unworthy (Briere & Runtz, 1990).

Studies show that EA incurred in early childhood can lead to neurodevelopmental difficulties, actually altering the course of a growing brain's development; resulting in problems with socioemotional development, self-regulation skills, decreased learning capacity, and a variety of other negative outcomes over time. Some researchers have even suggested that psychological abuse is the core factor underlying all forms of childhood abuse, highlighting the similarity in effects and outcomes between all abuse groups (Yates, 2006).

Child neglect.

Definition of child neglect. Similarly to emotional abuse, child neglect can often be less visible and more difficult to discern, yet also quite pervasive and damaging. Characteristics of neglect include that it is perpetrated by a parent or caregiver, it happens on a recurring basis, and involves one or more of a child's developmental needs not being adequately met. There are many different types of neglect, the most common being physical and emotional. Physical neglect includes inadequate access to necessary food or nutrition, clothing, housing, hygiene, or exposure to unsafe or uncleanly living conditions. Emotional neglect includes emotional absence of a caregiver and/or caregiver's deprivation of a child's emotional needs. Other forms of neglect include failure to provide medical care; abandonment; caregiver failure to address developmental needs or foster developmental milestones; lack of supervision or being willfully detained in a locked room, vehicle, or other compartment; exposure to and/or failure to prevent involvement in illicit drug use and other criminal behaviors; and failure to ensure educational enrollment and attendance (Child Welfare Information Gateway, 2013).

Impact of neglect. Also much like child emotional abuse, chronic child neglect can have permanent consequences to the neurodevelopmental structure of the brain. Victims of chronic neglect often display cognitive difficulties; problems with emotional self-regulation, social competence, healthy attachment, the ability to effectively problem-solve or persevere at tasks; poor physical health; and increased language delays and conduct disorders. These issues can have profound impacts not only during childhood, but also throughout individuals' lifetimes (Child Welfare Information Gateway, 2013).

Many childhood victims of neglect are subject to several negative circumstances throughout their lives, both as a result of the neglect, and the contexts from within neglectful conditions often arise. Because of this, it can be difficult – as in many other forms of abuse – to determine what consequences are a direct result of the neglect, and which are a result of socioecological factors. However, neglect that occurs in early childhood, when the brain is at its most plastic state of development, is almost always linked to these adverse outcomes (DePanfilis, 2006).

Complex trauma.

Definition of complex trauma. Complex trauma occurs when individuals experience exposure to multiple or recurrent traumatic events over time. There is evidence indicating that once individuals have experienced one trauma, the likelihood of exposure to subsequent traumatic events increases. In a general population study of children who had experienced trauma, 70% of exposed children experienced multiple victimization events, with an average of three unique events reported (Fairbank, 2008). The Adverse Childhood Experiences (ACE) Study also noted similar results, citing that

of the 64% of 17,000 participants in their longitudinal study who experienced childhood trauma, 69% reported two or more incidents (Centers for Disease Control and Prevention, 2014).

Impact of complex trauma. The impact of complex trauma is particularly far-reaching, as it ties not only to how survivors view themselves, but also their view of the world around them and relationships with others. As much abuse occurs at the hands of caretakers, children learn from an early age that most people cannot be trusted, and that the world is a scary and unpredictable place. Complex trauma also impacts the body and brain's ability to develop normally, particularly in regard to stress response, somatic issues and executive functioning capabilities. Emotional responses often range from perceived complete overreaction and out-of-control behaviors, to emotional numbing or dissociation. In addition to individual consequences, the estimated economic cost of assessing, treating and intervening in cases of childhood abuse and maltreatment has been conservatively estimated at \$103.8 billion annually (NCTSN, 2015).

Differential Outcomes

Although controversial, the Rind & Tromovitch (1997, 2007) articles do bring up an important point, in that not all survivors achieve negative outcomes following childhood abuse. In fact, the majority of survivors do go on to lead productive and satisfactory lives, oftentimes without the assistance of therapy (Tromovitch & Rind, 2007; Gagnon, 1965; Valentine & Feinauer, 1993). As deMause (1998) noted, in some ways the field of child abuse research is still fairly new and undiscovered. Thus, it is

important to determine at what point in the literature the idea of differential outcomes in abuse survivors may have initially developed.

Early literature on CA noted that once children were exposed to an adverse trauma, the damage was both unavoidable and irreversible. However, in a 1967 study of adopted children who had been removed due to parental neglect and/or abuse, results indicated that after adjusting to the placement, 80-82% of children were functioning at the expected level, as assessed by parental satisfaction. The author also noted similar surprising results from a number of other then-recent studies, presenting the novel idea that negative outcome following childhood trauma may not always be the case (Kadushin, 1967).

Ecological perspective.

The idea that contextual factors might play a role in differential outcomes of abuse survivors began to emerge following Bronfenbrenner's (1977) socioecological theory of development (Gabarino & Crouter, 1978). Thus, the impact of abuse occurs within four environmental levels: individual, family, community and culture. Each of these levels represent the potential for varying degrees of protective and/or risk factors, depending on each individual's circumstance (Caldwell, Bogat & Davidson, 1988). Factors such as being of low socioeconomic status, stress on female-headed single-parent households, lack of housing stability, and social isolation were found to not only contribute to increased likelihood of child maltreatment, but also inherently detract from the potential protective factors available to abused children, thereby leading to decreased possibility of positive adaptation following CA (Gabarino & Crouter, 1978).

Prevention. The idea of prevention programming also emerged from a socioecological perspective. Researchers proposed that by targeting at-risk children, CA might be prevented, or at least its consequences might be ameliorated. This also suggests that if provided with the right supports, CA survivors might achieve more positive adaptations (Caldwell et al, 1988). Unfortunately, though, even today most CA prevention programs have been met with questionable support due to their often-mixed results or findings of limited effectiveness (Hansen, 2010). Researchers also argued that, similarly to the Rind & Tromovitch assertions, due to the apparent low base-rate of negative consequence for CA survivors, the social benefits of such programming do not outweigh the financial costs (Caldwell et al, 1998).

History of Resilience

Early accounts of resilience in the literature proposed the idea of “ego resilience” in young children, described as an ability to adapt capably and in “resourceful, tenacious, but elastic ways” under novel environmental demands. In contrast, other individuals may adapt in rigid and chaotic ways, unable to meet these demands. Such individuals were thereby deemed “unresilient,” and thus more likely to experience dysfunctional outcomes (Block & Turula, 1963, p. 946). A simplified idea of the ability to adapt can be likened back to coping style mechanisms – wherein those who are able to exhibit more flexible styles of coping may be more likely to achieve positive adaptation than those who do not (Rutter, 2007). These unresilient individuals were also described as rating highly on the personality trait of neuroticism (Block & Turula, 1963), a description that seemed not unlike the orchid children from the Boyce & Ellis (2005) article.

In the 1970s, research on atypical cases of schizophrenia – individuals who were able to live relatively productive lives in spite of their supposedly debilitating diagnosis – keyed into the idea of certain individuals achieving positive outcomes in spite of high risk. This led to an overarching desire within this new area to search out the protective factors that differentiated individuals with positive adaptations from those who were less psychologically adjusted (Luthar, Cicchetti & Becker, 2000). Anthony (1974) first labeled these individuals as “invulnerable;” however this was later changed to the term “resilient,” as to avoid implication that risk evasion was absolute and unchanging (Luthar et al, 2000, p. 544).

While early research was more focused on the individual personality characteristics of resilience, the trajectory later moved more toward resilience as derived from external protective factors, as well as determining the underlying processes by which resilience is able to contribute to outcomes of positive psychological functioning (Luthar et al, 2000). Luthar and colleagues (2000) posit that while the term “ego-resiliency” referred more to an individual trait, “resilience” should instead be considered as a “dynamic developmental process” spurred on by the exposure to adversity (Luthar et al, 2000, p. 546).

In other words, resilience can be conceptualized as a process that allows the interaction of protective factors and risk to result in promotion of a successful adaptation. Many researchers feel that individual characteristics are also a part of this process (Lam & Grossman, 1997). Overarching theory dictates that both genes and environment are inextricably linked in activating resilience. Biological processes may be a key

component of resilience, as described by qualities of planning, sense of personal agency and the ability to self-reflect. Environmental conditions (both positive and negative) such as family relationships, neighborhood characteristics, and socioeconomic status, may also influence the way that genes express themselves in terms of resilience, such as in the Dandelion and the Orchid (Rutter, 2013).

Traditionally, resilience was thought to be something that developed during childhood. However, in his annual research review, Rutter explained that some evidence indicates resilience can also be fostered in adulthood through critical “turning points” (Rutter, 2013, p. 478). One such protective factor leading to adulthood resilience included the onset of a supportive marital relationship. Another was found within the provision of educational opportunities to formerly disadvantaged personnel who joined the military. In both of these studies, the turning point events were significant in that they led to a change in participants’ peer groups, environments, potential socioeconomic status and/or views of their future and overall potential. In a sense, they afforded individuals with the opportunity to create “a discontinuity with the past that removes disadvantageous past options and provides new options for constructive change” (Rutter, 2013, p. 479). These studies lend support to the hypothesis that it is possible for resilience to be promoted later in life (Rutter, 2013).

Resilience and childhood abuse.

In his 1963 article, Henry Maas described the recovery of twenty young adults from early childhood neglect and traumatic separation as exemplary of the “resiliency, plasticity and modifiability of the human organism” (Maas, 1963, 66-67). This appears

to be one of the earlier uses of the word “resiliency” in connection with childhood abuse throughout the literature, although the preferred term is now considered “resilience” (Luthar et al, 2000, p. 546).

Yet more widespread research on the relationship between CA and resilience as a construct did not appear in the literature base until around the 1990s, again with a particular focus on CSA. One qualitative study on resilient female survivors of CSA described the following attributes as salient: the ability to find supportive relationships outside the family, self-regard, religion or spirituality, external attribution of blame, internal locus of control and recognition of personal power, and a general positive philosophy on life (Valentine & Feinauer, 1993). These conceptual findings have been echoed in a variety of qualitative and quantitative studies over time, linking these environmental and individual characteristics of resilience to positive survivor adaptation across the lifespan (Wright et al, 2005; DuMont et al, 2007; McClure et al, 2008; Rutter, 2007; Gust, 2000; Rew et al, 2001; etc).

Social support as a protective factor. Throughout the literature, it is clear that a major theme in external factors proposed to influence the development of resilience is that of social support. This support may take on the form of positive relationships with peers, family, caretakers, mentors, spouses or significant others, pets, academic environments, religious organizations, neighborhood communities, or simply just the feeling of belonging to a group; and survivors who possessed these external supports were more likely to achieve positive adaptations than those who did not (Wright et al, 2005; DuMont et al, 2007; McClure et al, 2008; Kia-Keating et al, 2010; Simpson, 2010;

Edmond et al, 2006; Jaffee et al, 2007; etc). As noted earlier, although social support can be helpful to all individuals, the ability to access this support was specifically advantageous to those experiencing a high level of adversity (Masten et al, 2009).

Implications. Perhaps what is so enticing about the idea of resilience in child abuse research is that if such characteristics as coping style, planning, agency and self-reflection can be taught over time, individuals may be able to learn to become resilient, thereby eventually achieving more positive psychological outcomes (Rutter, 2013). Studies also show that the presence of higher protective factors is associated with higher internal resilience, and better psychological functioning in survivors of CA (Lam & Grossman, 1997).

Again, while protective factors can be advantageous to all individuals, they are specifically relevant to those with histories of abuse or other high-risk adversities, as the risk serves as an activating factor to resilience (Lam & Grossman, 1997; Masten et al, 2009). If the idea of turning points, as posited by Rutter (2013) is in fact correct, then the opportunity would exist for a lifespan approach to creating and fostering resilience in recovery from CA; focusing on building personal strengths, enhancing positive coping skills, increasing external supports, and generating opportunities for success (Rutter, 2013). As these findings can have important implications for the treatment of CA survivors, more research is still needed in this area to examine the interrelationships among contextual supports, internal resilience qualities, and adaptive outcomes within adults exposed to childhood abuse.

Chapter Three: Method

The present study examined the potential moderating roles of environmental factors (i.e., social support) and individual or intrinsic factors (i.e., coping style) on the relationship between childhood abuse and positive adaptation. This chapter addresses the sample obtained for the current study, procedures, instruments utilized, and the research design implemented to test study hypotheses.

Participants and Procedure

A limitation of past studies on CA and resilience is the narrow scope of populations studied, whether it pertains to a specific group of people (e.g., college students), or a low number of study participants (typical of the nature of many qualitative studies). This decreased the overall generalizability of many of the results found (McClure et al, 2008; Simpson, 2010; Banyard & Williams, 2007). It is also difficult to obtain large samples of participants who are willing to openly discuss traumatic experiences. This is particularly true in the case of male survivors, as well as survivors who identify as people of color. Many studies concerning CA, and particularly CSA, focus solely on female survivors, while a few studies focus on men, and some focus on both genders (Grossman, Sorsoli, & Kia-Keating, 2006).

Therefore, it was important to attempt to draw participants from a broader demographic sample – including a variety of genders, ages, racial/ethnic groups, income and education levels, etc. – in order to help increase variability, and therefore

generalizability to the overall population of CA survivors (McClure et al, 2008; Beutler, 1993). Inclusion criteria for this study entailed being over the age of 18 and identifying as having experienced childhood abuse in the form of any of the following: physical, emotional, or sexual abuse and/or emotional or physical neglect.

Data collection for this study was completed entirely via the Internet, using Qualtrics, a secure online survey program provided through the University of Denver. No names, signatures or other identifiers were collected for study participants. However, participants did consent to complete a brief Demographic Questionnaire for descriptive information (see below and Appendix A for more details). Calls for participation included an anonymous survey link for potential participants to click on. The link directed participants to the study's informed consent, where individuals could decide whether or not to consent to participate in the study. A sample call for participation email with flyer text can be found in Appendix F.

Following IRB approval, the researcher reached out to friends, family and colleagues, as well as departmental and professional listservs to gain study participants. The study flyer was also posted on the APA Communities webpage, several Facebook pages geared toward supporting survivors of CA, and the researcher's personal LinkedIn and Facebook pages. Additionally, the researcher obtained permission to post the call for participants in several private support forums or websites for survivors of CA. These forums included: Help for Adult Victims of Child Abuse (HAVOCA), Adult Survivors of Child Abuse (ASCA), Pandora's Project, Fort Refuge, 1in6.org, and Survivor Network for Abuse by Priests (SNAP).

Because the survey by design was anonymous, it is difficult to determine exactly from where participants' responses originated. However, since many of the organizations mentioned above are not just national, but international, it can be assumed that the sample obtained was geographically diverse. The researcher was able to obtain consent from a total of 130 participants. Participants spent an average time of 32 minutes completing the survey. Thirteen of the surveys had missing or incomplete data. There were a total of 117 completed surveys at the end of data collection.

Measures

Demographic questionnaire.

Participants completed a brief demographic survey with questions regarding age, gender, race/ethnicity, religious affiliation, educational level, income level, and occupation in order to obtain descriptive statistics for the sample.

Childhood abuse.

The occurrence and severity of childhood abuse was measured using the *Childhood Trauma Questionnaire (CTQ)*, as developed by Bernstein & Fink (1998). The CTQ is a 28-item self-report tool measuring the construct of childhood abuse across the following five domains: physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect. Each item is rated on a Likert-type scale, with options ranging from 1 (never true) to 5 (very often true). For each of the five domains, there are five questions. Domain subscales are scored individually, with higher scores on each subscale indicating greater abuse intensity and severity in that particular domain. There are also 6 items that must be reverse coded. Thus, scores may range from 5 (no abuse) to 25 (most

severe abuse) on each subscale. Total scores can be summed, for an overall abuse severity rating. The survey also includes a 3-item Minimalization/Denial scale to detect underreporting, which is common in cases of abuse (Bernstein et al, 2003).

The instrument was normed on a sample of adults from a 20-year longitudinal study of community adolescents, and has been found to have high reliability and good convergent/divergent validity with other trauma history measures (Bernstein et al, 2003). In the initial validation study, all five of the subscales and the total scale achieved high internal consistency scores ($\alpha = .79$ to $.94$, and $.95$, respectively), as well as high test-retest reliability over a 2- to 6- month interval ($r = .88$) (Bernstein et al, 1994). The *CTQ* is especially useful in that it measures childhood abuse as part of a continuum, and not just as a static occurrence, leading to greater possibility for variability within samples (Bernstein et al, 2003).

Social support.

Protective factors, assessed by social support in this study, were measured using the *Multidimensional Scale of Perceived Social Support (MSPSS)*. Developed by Zimet, Dahlem, Zimet & Farley (1988), the *MSPSS* is a brief, 12-item self-report questionnaire rated on a Likert scale, ranging from 1 (very strongly disagree) to 7 (very strongly agree). The scale was created in order to further assess the role of social support, particularly during times of increased stress. Factor analyses of *MSPSS* items revealed that perceived social support emerged in three distinct domains: support from family, friends, and significant others. Although each subscale includes 4 items, the items are summed to create a total scale score, ranging from 12 to 84. The instrument was normed on a sample

of 275 college students, and achieved a total scale internal consistency of $\alpha = .88$. Cronbach's alphas for each of the three subscales were .87, .85, and .91, respectively. Total scale test-retest reliability was .85 (for the subscales, .85, .75, and .72, respectively). Construct validity was also consistent with hypothesized findings, in that higher social support was significantly related to lower depression and anxiety (Zimet et al, 1988).

Coping style.

Rutter (2007) discussed the potential importance of individual characteristics, such as coping style, in contributing to the development of resilience, and thereby positive psychological functioning. The *Brief COPE* (Carver, 1997) is a 28-item self-report scale measured on a 4-point Likert-type scale, with responses ranging from 1 (I haven't been doing this at all) to 4 (I've been doing this a lot), with higher scores representing higher usage of endorsed coping skills. The scale was designed in order to assess individuals' responses to a variety of stressors, such as illness diagnosis, natural disasters and important examinations (Carver, 1997). Because the occurrence of childhood abuse may impact individuals' ability to deal with stressful events throughout the lifespan, the present study will not focus on a particular event, but on reactions to stress in general (Rutter, 2007).

The instrument was validated using a community sample following the aftermath of Hurricane Andrew. Factor analyses revealed 14 subscales with 2 items each (active coping, planning, positive reframing, acceptance, humor, religion, using emotional support, using instrumental support, self-distraction, denial, venting, substance use,

behavioral disengagement and self-blame). Together the subscales contributed to 72.4% of the total variance, with internal consistencies ranging from .50 to .90 (Carver, 1997).

The author states that researchers can group the instrument subscales into particular categories based upon their interests and theoretical underpinnings of the researched topic. There is not necessarily a total scale score for this instrument, as the subscales measure a variety of different coping strategies. The four suggested subscales are: problem-focused coping, emotion-focused coping, avoidant coping, and support-seeking coping (Carver, 1997). It appears that each subscale can be attributed to either positive or negative coping styles. Research shows that problem-focused coping styles may be related to better overall health and life satisfaction outcomes; whereas avoidant and emotion-focused styles of coping are generally associated with poorer health outcomes and increased rates of depression (Boals et al, 2011).

There is also evidence suggesting that the proportion of problem-focused to emotion-focused or avoidant coping may have an impact on individuals' stress levels, psychological adjustment, life satisfaction, and overall quality of life. It appears that support-seeking coping may play a role in individuals' ability to access positive coping mechanisms; however, less information is known about the way in which this cluster of variables may impact psychological outcomes (Eisenbarth, 2012).

In this study, the items were analyzed according to theoretically based determinations of coping styles using the four groups described above. Reliability for the subscales has been found to range from $\alpha = .70$ (problem-focused coping) to $\alpha = .81$ (support-seeking coping). The problem-focused coping scale was formed from the

planning and active coping subscales; emotion-focused from humor and positive reframing subscales; avoidant coping from denial and behavioral disengagement; and support-seeking coping from the using emotional support and using instrumental support subscales (Eisenbarth, 2012).

Positive adaptation.

Positive adaptation was measured utilizing the construct of life satisfaction, which is consistent with one of the internal characteristics of positive development outlined by Masten and colleagues (2009). Diener and colleagues created the *Satisfaction With Life Scale (SWLS)* in 1985 in an effort to better assess positive life adaptations, and move away from the field's overarching focus on psychological distress measures. The idea of life satisfaction stemmed out of the positive psychology movement's focus on subjective well-being. The construct has also been related to salient domains such as academic or role performance and social support relationships (Pavot & Diener, 2008).

The SWLS is a very brief 5-item self-report measure rated on a Likert scale from 1 (strongly disagree) to 7 (strongly agree). Items are summed to obtain a total scale score ranging from 5 to 35, with higher scores representing higher life satisfaction. The scale has been utilized in a variety of cultures, with community and clinical populations, with adults and adolescents, exhibiting internal consistencies ranging from .79 to .89. It has been found to correlate negatively with measures of mental health distress, and to be predictive of certain future behaviors, such as suicidality (Pavot & Diener, 2008).

Research Design

Study hypotheses were tested using hierarchical multiple regression, to explore whether social support and coping style moderated the relationship between childhood abuse and life satisfaction. Moderation analyses seek to answer the question of “when” and “for whom” (Frazier, 2004, p. 116). In this instance, childhood abuse was the predictor variable and life satisfaction the outcome variable. Theoretically, the “when” was demonstrated by level of survivor social support; while the “for whom” was related to survivors’ ability to exhibit positive (i.e., problem-focused or support-seeking) coping styles. For example, does the relationship between childhood abuse and life satisfaction change when individuals have more or less social support? Does the relationship between childhood abuse and life satisfaction change when individuals utilize more or less positive coping strategies? Further, is there a three-way interaction between social support and coping, wherein the type of coping style changes the relationship between child abuse and life satisfaction at high and low levels of social support? These moderator variables should help to buffer (i.e., weaken) the potentially negative impact of childhood abuse on life satisfaction (Frazier, 2004).

Sample size.

In order to determine the sample size for this study, one must first assess the desired effect size. Effect sizes for interactions are generally small, and usually correspond to an R^2 value of .02 to .04 (Frazier, 2004). Medium and large effect sizes for multiple regression have been identified as $R^2 = .25$ and .40, respectively (Wuensch, 2009). Adequate power to test interaction effects is typically agreed upon at .80 (Frazier,

2004). Using G*Power 2 to conduct a priori power analysis, the necessary sample size to detect a small effect size was determined to be 550 participants at an effect size of .02, or less conservatively, 277 at .04 ($\alpha = .05$). For a medium effect size, only 48 participants would be needed (Faul, Erdfelder, Buchner & Lang, 2009). In some cases, significant interaction effects have been found in sample sizes smaller than 100 participants (e.g., Wei, Yeh, Chao, Carrera & Su, 2013). Therefore, the researcher's goal was to minimally obtain the sample size necessary for a medium effect size, with efforts made to obtain a large enough sample to detect a small effect. Due to IRB constraints because of the high-risk nature of the population, the researcher and dissertation committee felt satisfied with the sample size achieved, having greater than 100 completed surveys.

Chapter Four: Results

The findings of the statistical analyses associated with the study are presented in this chapter. All statistical analyses were performed using the IBM Statistical Package for the Social Sciences version 23.0 (SPSS 23.0). All statistical procedures used two-tailed tests of significance with the alpha level set at $p < .05$.

Preliminary Analyses

This portion of the chapter includes an analysis of missing data and how it was treated; participants' demographic information; and results of reliability analyses and descriptive statistics for the main study variables: childhood abuse, social support, coping style, and positive adaptation.

Missing data.

Out of the 130 participants who consented to take the survey, thirteen surveys were found to be incomplete. Of those incomplete surveys, three participants consented to take the survey, but did not fill out any of the survey questions; three participants stopped taking the survey after filling out the demographic questionnaire; and two participants filled out the survey through the CTQ. One participant answered up through Item 1 on the MSPSS; and four participants stopped taking the survey after the MSPSS. Because of this pattern of respondents gradually dropping off as the survey continued, it can be assumed that the data were missing not at random (MNAR). As specified by Osborne (2013), including MNAR data in analyses could potentially bias the study

results. In studies where the number of missing data was relatively low compared to the overall N , listwise deletion was found to be an acceptable method for dealing with surveys that could otherwise potential skew results (Osborne, 2013). Therefore, the following analyses will be representative of the 117 participants who did complete the survey in its entirety.

Participant demographics.

The survey was taken by adults of all ages, ranging from 18 to 72 years ($M = 37.46$, $SD = 12.09$). Of the 117 participants who completed the survey, 92.3% identified as female, 5.1% as male, 1.7% as transgender, and .9% as Other (“genderfluid”). 88.9% of participants identified as White, 5.1% as Multiracial, 1.7% as American Indian or Alaskan Native, 1.7% as Asian, and 2.6% as Other (respondents answered: “Metis,” “Mexican American,” and “Australian”). 94.9% of participants identified as Not Hispanic or Latino, and 5.1% as Hispanic or Latino. Of the participants, 25.6% identified as Christian, 12.8% as Catholic, 4.3% as Jewish, 1.7% as Buddhist, 10.3% as Agnostic, 13.7% as Atheist, 21.4% as None, and 10.3% as Other (respondents answered: “Unitarian Universalist,” “Quaker,” “Monotheist,” “personal,” “Wiccan,” “mixed,” and “spiritual”).

Overall, participants were rather educated, with .9% noting less than a high school education, 6% with a high school diploma or GED, 29.1% with some college, 29.9% with a Bachelors degree, 33.3% with a Masters degree or higher, .9% with Other (“professional degree”). In spite of being well educated, approximately one-third of participants (39.3%) reported earning less than \$20,000/year. 21.4% of participants reported earning between \$20,000 to \$39,999/year; 21.4% between \$40,000 to

\$69,999/year, and 16.2% earned \$70,000/year or higher. Two participants (1.7%) declined to answer this question. The range of occupations reported by participants was broad. Approximately one-third of the respondents that noted their careers were positions as psychologists, other mental health professionals, and graduate students. Due to the procedures used to collect data, this was not unexpected. The remaining two-thirds respondents' careers were diverse, ranging from paralegal, cashier, bus driver, accountant, IT, nanny, teacher, writer, administrative support, and unemployed or on SSDI.

Reliability analyses and descriptive statistics.

Childhood abuse. The CTQ demonstrated strong reliability for this study. Reliability for the total scale score was $\alpha = .91$. Cronbach's alpha for the scale scores were as follows: Emotional abuse, $\alpha = .89$; Physical abuse, $\alpha = .93$; Sexual abuse, $\alpha = .96$; Emotional neglect, $\alpha = .90$; and Physical neglect, $\alpha = .78$. These results are consistent or better than findings from the original validation study of the measure (Bernstein et al, 1994).

On the emotional abuse scale, participants scored a mean of 16.84, $SD = 5.78$. This mean score is indicative of higher or more severe emotional abuse ratings, according to the cutoffs specified in the instrument's manual (Bernstein & Fink, 1998). On the physical abuse scale, participants achieved $M = 10.78$, $SD = 6.49$ (moderate severity); and sexual abuse $M = 17.16$, $SD = 7.66$ (high severity). For emotional neglect, participant scores had a mean of 16.25, $SD = 5.06$ (moderate severity); and for physical neglect, $M = 10.74$, $SD = 4.52$ (moderate severity). These scores are indicative of this

particular demographic sample having experienced greater severity in terms of emotional and/or sexual abuse. The total scale score for the CTQ had a mean of 77.09 (highest score is 125) and standard deviation of 21.17. This indicates that participants' overall scores would be in the high-moderate range, but that there was also a good deal of variability in terms of severity across the sample.

Utilizing the severity scores specified in the manual for moderate to extreme severity, this researcher created a variable to assess as to whether participants had experienced multiple types of trauma, potentially resulting in complex trauma. Based upon this analysis, over half of the study population had experienced three or more types of abuse (66.7%).

Social support. For the MSPSS, reliability for the total scale score was $\alpha = .93$. Scale score reliability was also good, with alphas of .94, .93, and .92 for the Friends, Family, and Significant Others scales, respectively. These scores are also consistent or better than the original validation results (Zimet et al, 1988).

Descriptive statistics indicate that on average, participants felt better supported by friends and significant others than they did by family members (Friends: $M = 20.20$, $SD = 6.22$; Significant others: $M = 20.67$, $SD = 7.05$; Family: $M = 14.72$, $SD = 7.60$). This finding is not necessarily unexpected, given that most abuse occurs in the home, at the hands of parents and other caretakers. Overall, participants indicated a high-moderate degree of social support with variability ($M = 55.58$, $SD = 17.51$; highest score on the scale could be 84).

Coping style. Reliability analyses for the Brief COPE were performed using the research for compiling the following scales, as previously discussed in Chapter 3: problem-focused coping, emotion-focused coping, avoidant coping and support-seeking coping (Eisenbarth, 2012). Cronbach's alphas were $\alpha = .78, .67, .72,$ and $.82$ respectively. Participants appeared to gravitate more toward problem-focused and support-seeking coping styles ($M = 11.47, SD = 2.85; M = 10.90, SD = 2.94,$ respectively). The means and standard deviations for emotion-focused and avoidant coping were as follows: $M = 8.20, SD = 2.61; M = 7.18, SD = 2.80.$

Positive adaptation. The SWLS exhibited strong internal consistency, $\alpha = .92.$ On average, participants endorsed low-moderate life satisfaction, $M = 16.95, SD = 8.79$ (highest score could be 35). This result is also not necessarily unexpected, given the overall high severity of childhood abuse endorsed, and potentially negative impact this can have on the ability to achieve positive adaptation.

Summary. Table 1 summarizes the means and standard deviations for the study variables.

Table 1
Means and Standard Deviations of the Study Variables

Variable	M	SD
1. Age	37.46	12.09
2. Educ	3.91	.99
3. Income	2.15	1.13
4. CTQ	77.09	21.17
5. MSPSS	55.58	17.51
6. Prob	11.47	2.85
7. Emot	8.21	2.59
8. Avoid	7.20	2.82
9. Supp	10.86	2.95
10. SWLS	16.95	8.79

Note. Prob = problem-focused coping; Emot = emotion-focused coping; Avoid = avoidant coping; Supp = support-seeking coping; Ethn = ethnicity; Relig = religion; Educ = education level.

Plan of Analysis

Data was examined to assess that the assumptions for regression (normality, linearity and homoscedasticity) had been met, and all assumptions were met. No outliers needed to be deleted from the data. The data were examined for intercorrelations between the study variables (see Table 2 on the following page). Main study hypotheses were conducted using the PROCESS macro (Hayes, 2014) for SPSS. The macro automatically centers predictor and moderator variables to reduce problems with multicollinearity, as well as creating interaction terms to assess moderation effects. In accordance with study hypotheses, regression models were tested to assess moderation effects between CA and social support, CA and coping style, and finally, a three-way interaction between CA, social support and coping style.

Each analysis was also completed by abuse type (emotional abuse, physical abuse, sexual abuse, emotional neglect and physical neglect), and also by level of complex trauma, to assess if type of abuse experienced may have impacted the relationship between CA and life satisfaction. Because there were significant correlations between the main study variables and education, income and age, these variables were controlled for during the analyses. This caused two cases to be excluded from the primary analyses, due to those participants having omitted their income information.

In order to run the three-way interaction using PROCESS, researchers must enter the outcome variable (life satisfaction), independent variable (childhood abuse), covariates (education, income and age), and the proposed moderator variables (social support and coping style). It was hypothesized that the interaction terms would contribute unique variance to the regression equation. In the event of significant interaction effects, simple slopes analyses would be conducted to assess differences in relationships between CA and life satisfaction among survivors with high and low social support, as well as high and low ability to utilize various coping styles. It was hypothesized that high social support and high levels of positive coping styles would buffer the negative relationship between CA and life satisfaction.

Primary Analyses

It is important to note several statistically significant correlations between the main study variables (shown below in Table 2). There was a strong negative correlation between CA and social support, as well as between CA and life satisfaction. CA and

avoidant coping style were significantly positively correlated, indicating that survivors of childhood abuse may be more likely to engage in unhelpful coping strategies.

Table 2
Intercorrelations of the Study Variables

Variable	1	2	3	4	5	6	7	8	9	10
1. Age	--									
2. Educ	.11	--								
3. Income	.36**	.27**	--							
4. CTQ	.19*	-.19*	-.12	--						
5. MSPSS	-.04	.19*	.21*	-.54**	--					
6. Prob	.19*	.27**	.11	.12	.17	--				
7. Emot	.12	.10	.00	.02	.12	.44**	--			
8. Avoid	-.09	-.21*	-.15	.43**	-.50**	-.16	-.11	--		
9. Supp	.18	.20*	.11	-.00	.41**	.59**	.36**	-.22*	--	
10. SWLS	-.01	.35**	.30**	-.41**	.71**	.22*	.17	-.60**	.27**	--

Note. ** = Correlation is significant at the 0.01 level (2-tailed). * = Correlation is significant at the 0.05 level (2-tailed).

Meanwhile, there was a significant positive relationship between life satisfaction and social support, as expected. It may also be inferred that those who scored highly on social support were significantly less likely to utilize avoidant coping styles and more likely to use support-seeking coping styles. A moderate but significant positive relationship was observed between life satisfaction and both problem-focused and support-seeking coping styles, as well as a strong negative relationship between life satisfaction and avoidant coping.

Hypothesis 1: Social Support.

The first hypothesis of the study stated that after controlling for participant age, education and income, social support would moderate the relationship between childhood

abuse and life satisfaction. A regression analysis was completed to examine whether the relationship between childhood abuse and life satisfaction was dependent upon social support.

Table 3
Regression Model of Childhood Abuse, Social Support, and Life Satisfaction

Step	<i>B</i>	<i>S.E.B.</i>
Step 1		
Age	-.10	.07
Education	2.60**	.79**
Income	2.09**	.74**
Step 2		
Age	-.04	.05
Education	1.78**	.59**
Income	1.04	.56
Childhood Abuse	-.01	.03
Social Support	.32**	.04**
Interaction	-.002	.001
R^2	.57**	
ΔR^2	.01	

* $p < .05$. ** $p < .01$.

As shown in Table 3, the full regression model predicted 57% of the variance in life satisfaction. Childhood abuse was not a significant predictor of life satisfaction. Social support was a significant predictor of life satisfaction, however, the interaction between childhood abuse and social support did not account for a significant amount of unique variance in the regression model, $F(1, 108) = 1.70, p > .05, R^2 = .01$. Therefore, the hypothesis that social support would moderate the relationship between childhood abuse and life satisfaction was not met.

Abuse type. The regression model was run by each of the five abuse types and the complex trauma variable, and none of these interactions accounted for unique variance in the regression model.

Hypothesis 2: Coping Style.

The second hypothesis stated that after controlling for participant age, education and income, coping style would moderate the relationship between childhood abuse and life satisfaction. It was hypothesized that positive or “resilient” coping, such as problem-focused coping and support-seeking coping styles, would lead to more positive adaptation (greater life satisfaction) in survivors of childhood abuse.

Problem-focused coping. First, a regression model was run to assess whether problem-focused coping style moderated the relationship between childhood abuse and life satisfaction.

The full regression model of childhood abuse, problem-focused coping and life satisfaction accounted for 34% of the variance in life satisfaction, and problem-focused coping was a significant predictor of life satisfaction. Childhood abuse was also a significant negative predictor of life satisfaction. However, the interaction between childhood abuse and problem-focused coping did not add unique variance to the model, $F(1, 108) = 2.70, p > .05, R^2 = .02$.

Table 4
Regression Model of Childhood Abuse, Problem-Focused Coping, and Life Satisfaction

Step	<i>B</i>	<i>S.E.B.</i>
Step 1		
Age	-.10	.07
Education	2.60**	.79**
Income	2.09**	.74**
Step 2		
Age	-.05	.06
Education	1.61*	.76*
Income	1.59*	.68*
Childhood Abuse	-.15**	.03**
Problem-Focused Coping	.69**	.26**
Interaction	.02	.01
R^2	.34**	
ΔR^2	.02	

* $p < .05$. ** $p < .01$.

Abuse type. The regression model was run for each abuse type, and complex trauma (each one taking the place of childhood abuse in the model). A significant interaction was found in the model between emotional abuse, problem-focused coping and life satisfaction. The full model accounted for 33% of the variance in life satisfaction. Both problem-focused coping and emotional abuse were significant predictors of life satisfaction. Additionally, the interaction between problem-focused coping and emotional abuse did contribute unique variance to the model, $F(1, 108) = 4.26, p < .05, R^2 = .03$.

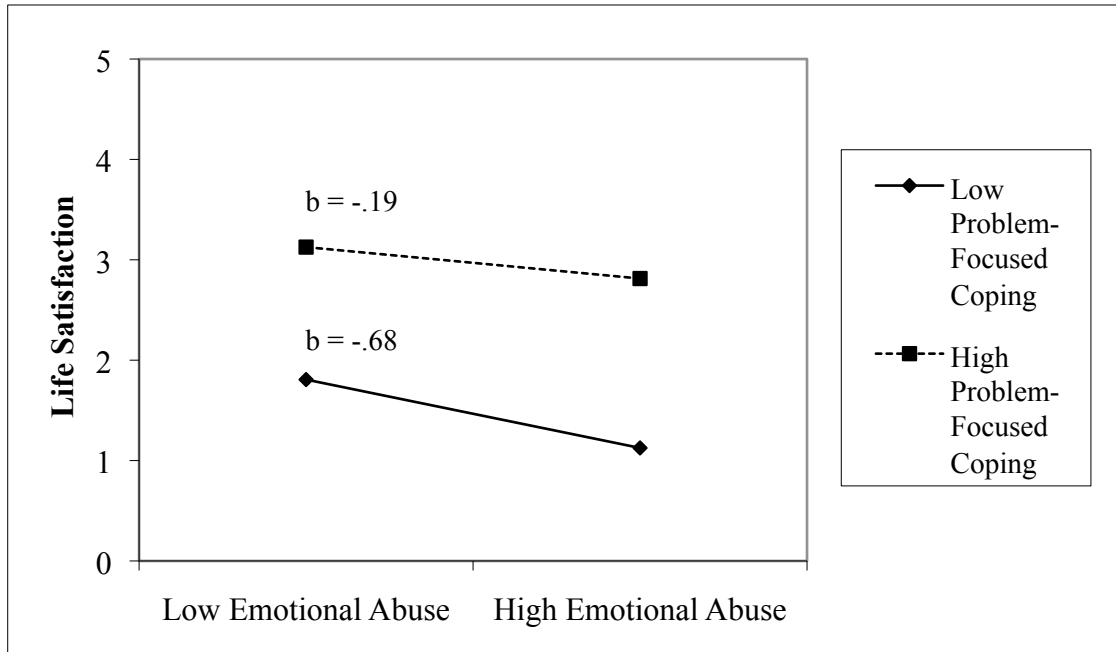
Table 5
Regression Model of Emotional Abuse, Problem-Focused Coping, and Life Satisfaction

Step	<i>B</i>	<i>S.E.B.</i>
Step 1		
Age	-.10	.07
Education	2.60**	.79**
Income	2.09**	.74**
Step 2		
Age	-.08	.06
Education	2.01**	.75**
Income	1.69*	.69*
Emotional Abuse	-.43**	.13**
Problem-Focused Coping	.68**	.26**
Interaction	.09*	.04*
R^2	.33**	
ΔR^2	.03*	

* $p < .05$. ** $p < .01$.

Figure 1 shows problem-focused coping style moderating the relationship between emotional abuse and life satisfaction.

Figure 1. Simple slopes analysis for the regression model of emotional abuse, problem-focused coping, and life satisfaction.



There was a significant negative interaction between emotional abuse and life satisfaction at low and mid-levels of problem-focused coping ($b = -.68$, $SE_b = .16$, $p < .001$; and $b = -.43$, $SE_b = .13$, $p < .001$ respectively). This negative interaction became less strong and non-significant as survivors used high levels of problem-focused coping strategies (i.e., making plans and actively trying to deal with the problem; $b = -.19$, $SE_b = .19$, $p > .05$). In other words, problem-focused coping appeared to buffer the relationship between emotional abuse and life satisfaction. Thus, Hypothesis 2 was supported for problem-focused coping style.

Emotion-focused coping. Secondly, it was assessed whether emotion-focused coping style significantly altered the relationship between childhood abuse and life satisfaction.

Table 6
Regression Model of Childhood Abuse, Emotion-Focused Coping, and Life Satisfaction

Step	<i>B</i>	<i>S.E.B.</i>
Step 1		
Age	-.10	.07
Education	2.60**	.79**
Income	2.09**	.74**
Step 2		
Age	-.05	.07
Education	1.98**	.75**
Income	1.73**	.69**
Childhood Abuse	-.14**	.04**
Emotion-Focused Coping	.48	.28
Interaction	.01	.01
R^2	.31**	
ΔR^2	.004	

* $p < .05$. ** $p < .01$.

The regression model of childhood abuse, emotion-focused coping and life satisfaction accounted for 31% of the variance in life satisfaction and this was significant. Childhood abuse was a significant negative predictor of life satisfaction, and emotion-focused coping was not a significant predictor of life satisfaction. The interaction between childhood abuse and emotion-focused coping did not contribute unique variance to the model, $F(1, 108) = .62, p > .05, R^2 = .004$.

Abuse type. The regression model of emotion-focused coping and life satisfaction was run with each of the five abuse types and complex trauma replacing childhood abuse as the predictor variable, and none of these interactions accounted for unique variance in the full regression models.

Avoidant coping. It was also explored as to whether avoidant coping would significantly alter the relationship between childhood abuse and life satisfaction. In this

case, it would be inferred that avoidant or “non-resilient” coping might lead to poorer life satisfaction outcomes for survivors of childhood abuse.

Table 7
Regression Model of Childhood Abuse, Avoidant Coping, and Life Satisfaction

Step	<i>B</i>	<i>S.E.B.</i>
Step 1		
Age	-.10	.07
Education	2.60**	.79**
Income	2.09**	.74**
Step 2		
Age	-.08	.06
Education	1.66**	.66**
Income	1.57**	.61**
Childhood Abuse	-.05	.03
Avoidant Coping	-1.55**	.25**
Interaction	.02	.01
R^2	.48**	
ΔR^2	.02	

* $p < .05$. ** $p < .01$.

As shown in Table 7, the full regression model predicted 48% of the variance in life satisfaction. Avoidant coping was a significant negative predictor of life satisfaction, though childhood abuse was not. The interaction between childhood abuse and avoidant coping did not account for a significant amount of unique variance in the regression model, $F(1, 108) = 3.10, p > .05, R^2 = .02$.

Abuse type. The regression model of avoidant coping and life satisfaction was run with each of the five abuse types and complex trauma replacing childhood abuse as the predictor variable, and none of these interactions accounted for unique variance in the full regression models.

Support-seeking coping. Finally, a regression model was run to assess whether support-seeking coping style would moderate the relationship between childhood abuse and life satisfaction.

The full regression model of childhood abuse, support-seeking coping style and life satisfaction accounted for 35% of the variance in life-satisfaction. Both support-seeking coping and childhood abuse were significant predictors of life satisfaction. Additionally, the interaction between support-seeking coping and childhood abuse did contribute unique variance to the model, $F(6, 108) = 3.86, p = .05, R^2 = .02$.

Table 8
Regression Model of Childhood Abuse, Support-Seeking Coping, and Life Satisfaction

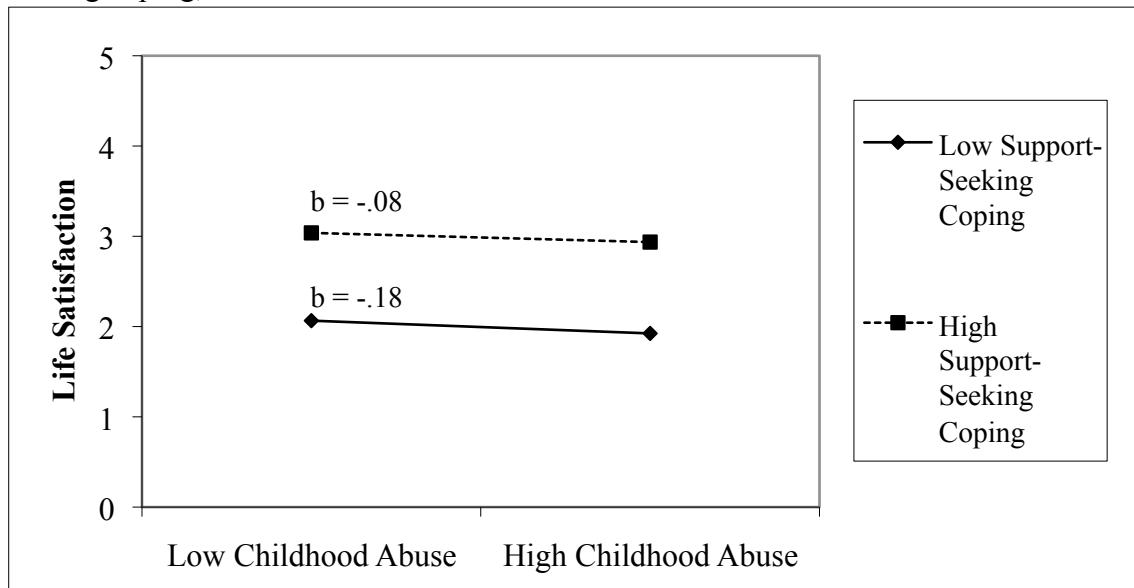
Step	<i>B</i>	<i>S.E.B.</i>
Step 1		
Age	-.10	.07
Education	2.60**	.79**
Income	2.09**	.74**
Step 2		
Age	-.05	.06
Education	1.74*	.73*
Income	1.65*	.67*
Childhood Abuse	-.13**	.03**
Support-Seeking Coping	.63**	.24**
Interaction	.02*	.06*
R^2	.35**	
ΔR^2	.02*	

* $p < .05$. ** $p < .01$.

On the following page, Figure 2 illustrates support-seeking coping style moderating the relationship between childhood abuse and life satisfaction. There was a significant negative interaction between childhood abuse and life satisfaction at low and

mid-levels of support-seeking coping style (for low support-seeking coping, $b = -.18$, $SE_b = .04$, $p < .001$; and mid, $b = -.13$, $SE_b = .03$, $p < .001$). This negative interaction became less strong and non-significant as survivors reported high levels of seeking out support as a form of coping, suggesting that support-seeking coping buffered the relationship between childhood abuse and life satisfaction ($b = -.08$, $SE_b = .05$, $p > .05$). Thus, Hypothesis 2 was supported for support-seeking coping style, as this particular coping style did buffer the relationship between childhood abuse and life satisfaction.

Figure 2. Simple slopes analysis for the regression model of childhood abuse, support-seeking coping, and life satisfaction.



Abuse type. The regression model was run with each abuse type and complex trauma taking the place of childhood abuse as the predictor variable. A significant interaction was found in the model of emotional abuse, support-seeking coping and life satisfaction. The full model accounted for 34% of the variance in life satisfaction. Both support-seeking coping and emotional abuse were significant predictors of life

satisfaction. Additionally, the interaction between support-seeking coping and emotional abuse did contribute unique variance to the model, $F(1, 108) = 4.57, p < .05, R^2 = .03$.

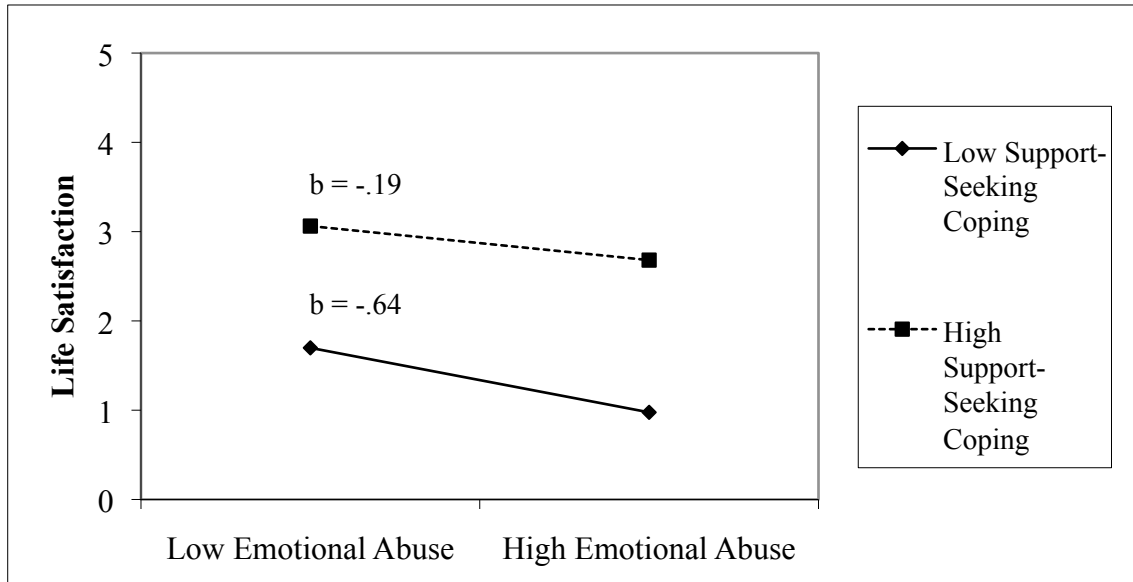
Table 9
Regression Model of Emotional Abuse, Support-Seeking Coping, and Life Satisfaction

Step	<i>B</i>	<i>S.E.B.</i>
Step 1		
Age	-.10	.07
Education	2.60**	.79**
Income	2.09**	.74**
Step 2		
Age	-.09	.06
Education	2.20**	.73**
Income	1.71**	.68**
Emotional Abuse	-.41**	.12**
Support-Seeking Coping	.70**	.24**
Interaction	.08*	.04*
R^2	.34**	
ΔR^2	.03*	

* $p < .05$. ** $p < .01$.

Figure 3 on the next page shows the simple slopes analysis of support-seeking coping moderating the relationship between emotional abuse and life satisfaction.

Figure 3. Simple slopes analysis for the regression model of emotional abuse, support-seeking coping, and life satisfaction.



There was a significant negative interaction between emotional abuse and life satisfaction at low and mid-levels of support-seeking coping (for low levels, $b = -.64$, $SE_b = .15$, $p < .001$; and for mid-levels, $b = -.41$, $SE_b = .12$, $p < .01$). This negative interaction became less strong and non-significant as survivors reported high levels of seeking out support as a coping style ($b = -.19$, $SE_b = .17$, $p > .05$). Thus, support-seeking coping appeared to buffer the relationship between emotional abuse and life satisfaction. By specifying emotional abuse as the predictor in this model, the interaction became slightly stronger than when childhood abuse in general is the predictor in the regression model with support-seeking coping and life satisfaction.

Hypothesis 3: Social Support and Coping Style.

The final hypothesis of the study stated that there would be a three-way interaction between social support, coping style and childhood abuse in predicting life satisfaction. Because each coping style was examined separately, three-way interactions were examined for each of the proposed coping styles.

Problem-focused coping. A regression analysis was run to examine whether a three-way interaction existed between social support, problem-focused coping style and childhood abuse in predicting life satisfaction.

The full regression model of childhood abuse, social support, and problem-focused coping predicted 60% of the variance in life satisfaction. Both problem-focused coping and social support were significant predictors of life satisfaction, and childhood abuse was not. Additionally, the three-way interaction did not account for a significant amount of unique variance in the regression model, $F(1, 104) = 2.95, p > .05, R^2 = .01$.

Table 10
Three-way Interaction of Childhood Abuse, Social Support, Problem-Focused Coping, and Life Satisfaction

Step	<i>B</i>	<i>S.E.B.</i>
Step 1		
Age	-.10	.07
Education	2.60**	.79**
Income	2.09**	.74**
Step 2		
Age	-.07	.05
Education	1.61**	.62**
Income	1.15*	.55*
Childhood Abuse	-.03	.03
Social Support	.28**	.40**
Problem-Focused Coping	.56*	.25*
Three-way Interaction	.0009	.0008
R^2	.60**	
ΔR^2	.01	

* $p < .05$. ** $p < .01$.

Emotion-focused coping. A regression analysis was run to explore the three-way interaction between social support, emotion-focused coping style and childhood abuse in predicting life satisfaction.

The model of childhood abuse, social support and emotion-focused coping predicted 58% of the variance in life satisfaction. Social support was a significant predictor of life satisfaction, but childhood abuse and emotion-focused coping were not. Additionally, the three-way interaction did not account for a significant amount of unique variance in the regression model, $F(1, 104) = .09, p > .05, R^2 = .0004$.

Table 11
Three-way Interaction of Childhood Abuse, Social Support, Emotion-Focused Coping, and Life Satisfaction

Step	<i>B</i>	<i>S.E.B.</i>
Step 1		
Age	-.10	.07
Education	2.60**	.79**
Income	2.09**	.74**
Step 2		
Age	-.05	.05
Education	1.75**	.61
Income	1.09*	.56*
Childhood Abuse	-.01	.03
Social Support	.31**	.04**
Emotion-Focused Coping	.30	.27
Three-way Interaction	.0002	.0006
R^2	.58**	
ΔR^2	.0004	

* $p < .05$. ** $p < .01$.

Avoidant coping. A regression analysis was run to examine whether a three-way interaction existed between social support, avoidant coping style and childhood abuse in predicting life satisfaction.

Table 12
Three-way Interaction of Childhood Abuse, Social Support, Avoidant Coping, and Life Satisfaction

Step	<i>B</i>	<i>S.E.B.</i>
Step 1		
Age	-.10	.07
Education	2.60**	.79**
Income	2.09**	.74**
Step 2		
Age	-.07	.05
Education	1.39*	.57*
Income	1.15*	.52*
Childhood Abuse	.04	.03
Social Support	.26**	.04**
Avoidant Coping	-.96**	.24**
Three-way Interaction	.0003	.0004
R^2	.64**	
ΔR^2	.0021	

* $p < .05$. ** $p < .01$.

The regression model of childhood abuse, social support and avoidant coping predicted 64% of the variance in life satisfaction. Both social support and avoidant coping were significant predictors of life satisfaction, but childhood abuse was not. The three-way interaction did not account for a significant amount of unique variance in the regression model, $F(1, 104) = .61, p > .05, R^2 = .0021$.

Support-seeking coping. Finally, a regression analysis was completed to explore whether a three-way interaction existed between social support, support-seeking coping style and childhood abuse in predicting life satisfaction.

Table 13
Three-way Interaction of Childhood Abuse, Social Support, Support-Seeking Coping, and Life Satisfaction

Step	<i>B</i>	<i>S.E.B.</i>
Step 1		
Age	-.10	.07
Education	2.60**	.79**
Income	2.09**	.74**
Step 2		
Age	-.04	.05
Education	1.79**	.60**
Income	1.11*	.56*
Childhood Abuse	-.01	.04
Social Support	.31**	.04**
Support-Seeking Coping	.02	.26
Three-way Interaction	.0000	.0005
R^2	.59**	
ΔR^2	.0000	

* $p < .05$. ** $p < .01$.

The full regression model of childhood abuse, social support and support-seeking coping predicted 59% of the variance in life satisfaction. Social support was a significant predictor of life satisfaction, but childhood abuse and support-seeking coping were not. Additionally, the three-way interaction did not account for a significant amount of unique variance in the regression model, $F(1, 104) = .0023, p > .05, R^2 = .0000$.

Abuse type. Each three-way interaction analysis was also run replacing childhood abuse with each of the five individual abuse types, as well as complex trauma. None of these interactions led to statistically significant results.

Chapter Five: Discussion

This study tested Masten and colleagues' (2009) theoretical model of resilience using moderation analysis. According to this paradigm, childhood abuse represented the risk, social support acted as a protective factor, and coping style served as the risk-activated protective factor, assessing for positive adaptation (in this case, life satisfaction) (Masten et al, 2009). Rutter (2007) called for a shift in the resilience literature from the examination of variables contributing to resilient outcomes, to focusing on the “processes or mechanisms” by which individuals are able to achieve positive adaptation (Rutter, 2007, p. 205). That is, what do individuals *do* to deal with the obstacles they face?

Rutter (2007; 2013) also calls for a focus on gene-environment (G x E) interactions, and the role this may play in either allowing some individuals to better access coping and support mechanisms; while also making it more difficult for others to access these, therefore leading to lower levels of resilience, less positive adaptation, and thereby, greater levels of resulting psychopathology. Boyce & Ellis (2005) also referred to “Reactivity x Context,” wherein high-stress reactivity may act in a “bivalent manner,” leading to higher risk of maladaptive outcomes in high stress situations, but actually acting to diminish that risk in lower stress conditions (Boyce & Ellis, 2005, p. 283).

Study Findings

The present study attempted to examine both protective/environmental variables (social support) and processes/mechanisms (coping style) leading to positive adaptation

following childhood abuse in the hopes of contributing to the overall literature base on the external vs. internal resilience debate. Support for the hypotheses of the present study were mixed. Hypothesis 1, which looked at social support moderating the relationship between childhood abuse and life satisfaction was not supported under any of the possible conditions. On average, participants reported a moderate to high degree of social support, and felt more supported by friends and significant others than by family. However, this substantial degree of social support did not appear to have a statistically significant impact on participants' life satisfaction following abuse during childhood.

Hypothesis 2 was met in the sense that it appears positive coping styles did significantly moderate the relationship between childhood abuse and life satisfaction. Specifically, individuals who were able to utilize or seek out their support systems as a form of coping were more likely to experience life satisfaction than those who were not. This was particularly helpful for survivors who experienced emotional abuse during childhood. This was also true of problem-focused coping for emotional abuse only. In both cases, these positive coping styles appeared to have a buffering effect on the impact of childhood abuse on life satisfaction. That is, as the ability to use positive coping increased, the negative relationship between childhood abuse and life satisfaction became statistically non-significant.

These findings help contribute to the research base in terms of moving away from static variables, and moving toward understanding the underlying processes that contribute to resilient outcomes (Luthar et al, 2000; Rutter, 2007). Luthar and colleagues (2000) also discussed findings from the literature where individuals' ability to access

supports had a significant impact on positive functioning. This makes sense within the current study, as it seems higher life satisfaction had more to do with individuals' ability to access support than whether or not they felt that support existed in their lives. Banyard & Williams (2007) noted that survivors with worse coping experienced notably worse adaptation over time. This was not necessarily the case for the current study, as there was not a significant negative interaction observed for use of emotion-focused or avoidant coping strategies.

By level of ability to access positive coping, individuals who appeared to have high levels of positive coping style achieved higher levels of life satisfaction on average than those who did not. While this was impacted somewhat by abuse severity, high positive coping appeared to have a greater overall impact on life satisfaction. In this way, individuals who were able to find positive adaptation, even in the face of high abuse severity might be likened to the "dandelion" children from Boyce & Ellis's (2005) theory of biological sensitivity to context. In the analogy of the "orchid" children, perhaps it is these children that, regardless of abuse severity, were less able to access positive coping mechanisms.

In other words, based upon the study results, it appears that some people are more able to access these coping mechanisms, regardless of abuse level and regardless of existent social support. In this way, the study provides more evidence supporting the theory of internal resilience (rather than external resilience by way of protective factors). However, while to an extent coping style may be intrinsic, it can also be taught, and this point will be discussed further in the implications section.

Based upon these findings, one might ask whether or not the level of social support that individuals felt they had may have impacted their ability to access adaptive coping styles. Based upon the analyses for Hypothesis 3, no three-way interactions between social support and any of the coping styles, or for any of the abuse types, had a significant impact on life satisfaction. This indicates that for this particular population, level of social support did not have a significant impact on individuals' ability to utilize particular coping strategies in order to buffer the impact of childhood abuse on life satisfaction.

Control variables.

Because there were significant correlations between the main study variables and the demographic variables of income and education (and to a lesser extent, age), these variables were controlled for during analyses. It can be assumed that those who make more money and are more highly educated may have greater access to resources and supports. Additionally, they may also feel more competent and confident in themselves, leading to better ability to access positive coping mechanisms. Past studies have shown that a sense of academic mastery and future orientation, the ability to make plans and be goal-directed, and graduating from high school have had an impact on whether individuals are able to be resilient following childhood abuse (Edmond et al, 2006; Klika & Herrenkohl, 2013).

Complex trauma.

Approximately 67% of the study population experienced “complex trauma,” as described by the experience of multiple types of abuse. This may seem like a relatively

high percentage, which could potentially impact results. However, as referenced by several notable publications, including the ACE Study (Centers for Disease Control and Prevention, 2014) and Fairbank's (2008) report for the National Center for PTSD, this number is actually in line with experiences of the general population of abuse and trauma survivors. Therefore, this number should not have had a notable impact on the study results, above and beyond that of other studies on abuse survivors. Efforts were made to assess impact by number of complex trauma events, and no statistically significant results were found. In fact, Dumont and colleagues found that individuals who had experienced a higher number of stressful life events during adolescence were found to become more resilient following these events (Dumont et al, 2007).

Implications for Research and Practice

The current study sought to add to the existing literature base on resilience studies by continuing to explore the characteristics or processes needed for individuals to achieve positive adaptation following the experience of childhood abuse. In this study, it appeared that the ability to access positive coping resources, particularly, the ability to seek out support from others, and somewhat, the ability to plan out and actively deal with current stressors mitigated the relationship between childhood abuse and life satisfaction. Moving forward, it will be important to understand through research and practice what mechanisms allow individuals to be more or less able to access these coping strategies.

Individual factors.

For example, Jaffee and colleagues (2007) discussed the implications of bi-directionality in person-environment interactions. Regardless of whether adversity has

been experienced or not, individuals who are able to express openness to help and interest in goal orientation are more likely to elicit positive responses from others, thereby fostering further supports and most likely, positive adaptations in the future. Whereas individuals who appear avoidant, aggressive or self-deprecating are more likely to be rejected by others or viewed in a negative light, thereby increasing their tendency toward continued maladaptation over time (Jaffee et al, 2007). Rutter (2013) echoed that individuals' ability to engage in planning and a sense of self-agency were more likely to develop a positive self-concept and to be viewed well by others. This in turn might impact their perceived ability to access positive coping styles.

As the present study looked at adult survivors of child abuse, it is important to consider how their coping styles (which may be intrinsic) have implicated their overall adaptation from an early age until present day. Anecdotally, the effects of these trajectories can often be witnessed in clinical practice, in terms of those that respond better to therapeutic intervention. A natural objective of most psychotherapy involves teaching and fostering the ability of clients to utilize adaptive coping skills in order to achieve positive change. Clients who appear better able to implement these tools are also more likely to receive praise and encouragement from their therapists and others around them, thereby continuing to strengthen their ability to feel confident in themselves moving forward.

In their major longitudinal study of children who had experienced abuse, DuMont and colleagues found that 11% of "non-resilient" adolescents later became resilient in adulthood (DuMont et al, 2007, p. 255), which is optimistic in terms of the ability to alter

trajectories. This change appeared related to having a supportive spouse or partner (DuMont et al, 2007). Rutter (2013) explored the idea of turning points, in that resilience may be able to be fostered later in life concurrent with a significant life event. In the above example, perhaps the addition of a supportive spouse or partner in survivors' lives assisted their ability to become resilient, also resulting in greater life satisfaction and overall positive adaptation. This result has also been demonstrated with other turning points, such as joining the military and educational achievement (Rutter, 2013).

In this case, any major life event which is viewed by an individual as positive (graduation, career, birth, etc.) could result in a turning point and lead to the ability to achieve positive adaptation. Hopefully, the creation of such life events through the therapeutic process could similarly foster resilience and enhance individuals' ability to positively cope following adversity. However, more information is still needed in order to parse out these complex processes.

Protective factors.

These observations also call attention to the importance of increased need for interventions that take a socioecological perspective, targeting not just individuals, but the multi-systemic contexts that impact their lives. Studies have shown that when children have a supportive parent or adult mentor, they are more able to achieve positive adaptation (McClure et al, 2008). The National Child Traumatic Stress Network (NCTSN) notes the importance of parents and caregivers in the role of children's recovery from traumatic experiences. Evidence-based treatments aimed at early intervention for childhood trauma, such as Trauma-Focused Cognitive Behavioral Therapy (TFCBT),

highlight the need to incorporate parents into treatment in order to best support children's needs (NCTSN, 2015).

Neighborhood characteristics may also inherently play a role, as those with less financial resources are more apt to live in dangerous or chaotic environments, which can impact access to resources, exposure to continued traumatic events, children's sense of safety/worldview, and parental stress levels (Jaffee et al, 2007). Conversely, other studies have found that neighborhood characteristics did have a significant impact; or more so that they moderated the role between parental support and individual resilience, tying into the idea that parents who are less stressed will better be able to support their children's well-being (DuMont et al, 2007).

Emotional abuse.

It is also important to consider why there was an interaction seen specifically in the case of childhood emotional abuse (EA). EA has long been described as one of the most difficult forms of abuse to detect, operationalize and treat (Moeller et al, 1993). It has also been posited as a potential underlying factor in all forms of abuse, highlighting its overarching significance (Yates, 2006). Survivors of EA are more likely to experience low self-esteem, feelings of worthlessness and to be highly self-critical (Briere & Runtz, 1990). Their worldview, sense of safety and ability to develop strong, caring relationships is all the more impacted (NCTSN, 2015). Perhaps it is because of this that the ability to be able to access support and to feel competent in making a difference in their own problems is all the more relevant to these specific survivors. More research in this particular area will be beneficial to enhancing the overall literature base.

It is important to note that in this study, abuse types were analyzed individually in order to better understand the data. However, in reality, different types of childhood abuse do not occur in a vacuum. As such, these analyses might not reflect lived experiences as accurately as hoped. Since approximately two-thirds of the study population scored in the moderate to high range on multiple types of abuse, it is likely that the emotional abuse group included in this analysis also experienced other types of childhood trauma. A correlational analysis of childhood emotional abuse and complex trauma revealed that these variables were highly correlated ($r = .80, p < .01$), suggesting that participants in the study who reported emotional abuse also experienced at least one other abuse type.

Limitations

This study was subject to several limitations that may have potentially impacted the results. The most notable limitation was most likely related to the issue of power in regression analyses. Although some studies have been able to find significant interaction effects with a sample size of 100 or less participants (Wei et al, 2013), this appears to be more the exception than the rule. In the initial estimation, the number of participants computed to detect a small interaction would be from 277 to 550, and for a medium effect, only 48 (Faul et al, 2009). The current study achieved a total of 115 surveys that were used in the primary analyses. While in some cases, a significant interaction was detected; it is possible that more interactions would have been seen had the dataset been larger.

Another possible limitation of the study could be the means used to collect data. The researcher solicited responses primarily from listservs and support communities. Therefore, there is a potential for these individuals to be more likely to seek out support as a form of coping. This may have inadvertently impacted the results of this study. Additionally, the impact that age of study participants had on the findings is unclear. While primary analyses controlled for age, it may be relevant to note that 65.8% of the sample was over the age of 30. Some studies show that social support is very much relevant to younger people in predicting psychological well being; and that as individuals grow older, social support becomes less relevant. In other words, age may have a buffering effect on psychological functioning, wherein as age increases, the need for social support decreases (Segrin, 2006).

The domains used to assess resilience are also open to question, part of the continued debate across the resilience literature (Rutter, 2013). For instance, some researchers have discussed whether positive adaptation as an exemplar of resilience should be measured by internal (e.g., life satisfaction, happiness) or external (e.g., income, academic success) outcomes of adjustment (Masten et al, 2009). Further, some have even posited that individual factors (i.e., in this study, coping style) should be viewed as the outcome of adjustment, rather than a moderating variable (Lam & Grossman, 1997). Since the study of resilience is both an empirical and conceptual one, this researcher determined the most appropriate way to analyze the hypotheses, based upon the available theory and research.

Additionally, some researchers have specified that in order to truly reflect positive adaptation, multiple adjustment domains should be assessed (Luthar et al, 2000); while this study had only one (life satisfaction). The most rigorous assessment of resilience over time would most likely entail a longitudinal study design, such as that used by DuMont and colleagues, and not a cross-sectional assessment such as that used in the current study due to limited resources and time. Finally, it is important to note that although the study population was geographically and economically diverse, it was neither racially nor ethnically diverse. The sample was also overwhelmingly female, despite efforts to collect from male participants (i.e., 1in6.org is a support site specifically for men). Grossman and colleagues (2006) note that underreporting of abuse experiences is particularly high in male and ethnically diverse populations.

Conclusion

Results of this study provide mixed support for the use of Masten and colleagues' (2009) model to test moderation effects. Support-seeking coping moderated the relationship between childhood abuse and life satisfaction; and both support-seeking coping and problem-focused coping moderated the relationship specifically between childhood emotional abuse and life satisfaction. However, social support did not moderate the relationship between childhood abuse and life satisfaction, and no significant three-way interactions were observed between the study variables. Methodological issues, particularly sample size, may help to explain these findings.

Future research is still needed in order to more clearly articulate the processes that contribute to positive adaptation following the adverse experience of childhood abuse.

Since as many as 50% of the world's children may be impacted by a variety of abusive events, this research is greatly needed (World Health Organization, 2010). Generally, the current study supports the theory that the construct of resilience can stem from internal qualities. More importantly though, while perhaps inherently intrinsic, the way in which we cope with stressful life events can be taught and learned – and that is the greatest positive adaptation of all.

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Appendix A: Demographic Questionnaire

1) Age: _____

2) Gender:

_____ Female

_____ Male

_____ Transgender

_____ Other (describe): _____

4) Race (check one that best applies):

_____ American Indian or Alaska Native

_____ Asian

_____ Native Hawaiian or Pacific Islander

_____ African or African American

_____ White

_____ Other (describe): _____

_____ Multiracial

5) Ethnicity:

_____ Hispanic or Latino

_____ Not Hispanic or Latino

6) Religious or Spiritual Affiliation:

_____ Christian

_____ Atheist

_____ Catholic

_____ Agnostic

_____ Jewish

_____ None

_____ Muslim

_____ Other (describe): _____

_____ Buddhist

7) Education Level:

_____ Less than High School

_____ High School Diploma or GED

_____ Some college

_____ Bachelors Degree

_____ Masters Degree or Higher

_____ Other (describe): _____

8) Income Level:

_____ Less than \$20,000/year

_____ \$40,000 - \$69,999/year

_____ \$20,000 - \$39,999/year

_____ \$70,000 and above

9) Occupation: _____

Appendix B: Childhood Trauma Questionnaire (CTQ)

1 2 3 4 5
Never True Rarely True Sometimes True Often True Very Often True

1. I didn't have enough to eat.
2. I knew that there was someone to take care of me and protect me.
3. People in my family called me things like "stupid," "lazy," or "ugly."
4. My parents were too drunk or high to take care of the family.
5. There was someone in my family who helped me feel that I was important or special.
6. I had to wear dirty clothes.
7. I felt loved.
8. I thought that my parents wished I had never been born.
9. I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.
10. There was nothing I wanted to change about my family.
11. People in my family hit me so hard that it left me with bruises or marks.
12. I was punished with a belt, a board, a cord, or some other hard object.
13. People in my family looked out for each other.
14. People in my family said hurtful or insulting things to me.
15. I believe that I was physically abused.
16. I had the perfect childhood.
17. I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or doctor.
18. I felt that someone in my family hated me.
19. People in my family felt close to each other.
20. Someone tried to touch me in a sexual way, or tried to make me touch them.
21. Someone threatened to hurt me or tell lies about me unless I did something sexual with them.
22. I had the best family in the world.
23. Someone tried to make me do sexual things or watch sexual things.
24. Someone molested me.
25. I believe that I was emotionally abused.
26. There was someone to take me to the doctor if I needed it.
27. I believe that I was sexually abused.
28. My family was a source of strength and support.

Appendix C: Multidimensional Scale of Perceived Social Support (MSPSS)

Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**
 Circle the "2" if you **Strongly Disagree**
 Circle the "3" if you **Mildly Disagree**
 Circle the "4" if you are **Neutral**
 Circle the "5" if you **Mildly Agree**
 Circle the "6" if you **Strongly Agree**
 Circle the "7" if you **Very Strongly Agree**

1.	There is a special person who is around when I am in need.	1	2	3	4	5	6	7	SO
2.	There is a special person with whom I can share my joys and sorrows.	1	2	3	4	5	6	7	SO
3.	My family really tries to help me.	1	2	3	4	5	6	7	Fam
4.	I get the emotional help and support I need from my family.	1	2	3	4	5	6	7	Fam
5.	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7	SO
6.	My friends really try to help me.	1	2	3	4	5	6	7	Fri
7.	I can count on my friends when things go wrong.	1	2	3	4	5	6	7	Fri
8.	I can talk about my problems with my family.	1	2	3	4	5	6	7	Fam
9.	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7	Fri
10.	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7	SO
11.	My family is willing to help me make decisions.	1	2	3	4	5	6	7	Fam
12.	I can talk about my problems with my friends.	1	2	3	4	5	6	7	Fri

The items tended to divide into factor groups relating to the source of the social support, namely family (Fam), friends (Fri) or significant other (SO).

Appendix D: Brief COPE

(Instructions are geared toward the researchers' study of patients who have recently been diagnosed with a major illness, but may be tailored to address other populations as well).

These items deal with ways you've been coping with the stress in your life since you found out you were going to have to have this operation. There are many ways to try to deal with problems. These items ask what you've been doing to cope with this one. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

- 1 = I haven't been doing this at all
- 2 = I've been doing this a little bit
- 3 = I've been doing this a medium amount
- 4 = I've been doing this a lot

1. I've been turning to work or other activities to take my mind off things.
2. I've been concentrating my efforts on doing something about the situation I'm in.
3. I've been saying to myself "this isn't real."
4. I've been using alcohol or other drugs to make myself feel better.
5. I've been getting emotional support from others.
6. I've been giving up trying to deal with it.
7. I've been taking action to try to make the situation better.
8. I've been refusing to believe that it has happened.
9. I've been saying things to let my unpleasant feelings escape.
10. I've been getting help and advice from other people.
11. I've been using alcohol or other drugs to help me get through it.
12. I've been trying to see it in a different light, to make it seem more positive.
13. I've been criticizing myself.
14. I've been trying to come up with a strategy about what to do.
15. I've been getting comfort and understanding from someone.
16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.
18. I've been making jokes about it.
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
20. I've been accepting the reality of the fact that it has happened.

21. I've been expressing my negative feelings.
22. I've been trying to find comfort in my religion or spiritual beliefs.
23. I've been trying to get advice or help from other people about what to do.
24. I've been learning to live with it.
25. I've been thinking hard about what steps to take.
26. I've been blaming myself for things that happened.
27. I've been praying or meditating.
28. I've been making fun of the situation.

<http://www.psy.miami.edu/faculty/ccarver/sclBrCOPE.html>

Subscales:

Active Coping: Items 2 and 7
Planning: Items 14 and 25
Positive Reframing: Items 12 and 17
Acceptance: Items 20 and 24
Humor: Items 18 and 28
Religion: Items 22 and 27
Using Emotional Support: Items 5 and 15
Using Instrumental Support: Items 10 and 23
Self-Distraction: Items 1 and 19
Denial: Items 3 and 8
Venting: Items 9 and 21
Substance Use: Items 4 and 11
Behavioral Disengagement: Items 6 and 16
Self-Blame: Items 13 and 26

(Carver, 1997)

Subscale Groupings:

Problem-focused coping: Planning and Active Coping subscales (Items 2, 7, 14, 25)
Emotion-focused coping: Humor and Positive Reframing subscales (Items 12, 17, 18, 28)
Avoidant coping: Denial and Behavioral Disengagement subscales (Items 3, 6, 8, 16)
Support-seeking coping: Using Emotional and Instrumental Support (Items 5, 10, 15, 23)

Does not include Acceptance, Religion, Self-Distraction, Venting, Substance Use or Self-Blame subscales.

(Eisenbarth, 2012)

Appendix E: Satisfaction with Life Scale (SWLS)

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 7 - Strongly agree
- 6 - Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

_____ In most ways my life is close to my ideal.

_____ The conditions of my life are excellent.

_____ I am satisfied with my life.

_____ So far I have gotten the important things I want in life.

_____ If I could live my life over, I would change almost nothing.

- 31 - 35 Extremely satisfied
- 26 - 30 Satisfied
- 21 - 25 Slightly satisfied
- 20 Neutral
- 15 - 19 Slightly dissatisfied
- 10 - 14 Dissatisfied
- 5 - 9 Extremely dissatisfied

Appendix F: Sample Call for Participation Email

Hello,

I have recently been approved to collect data for my dissertation research. My study involves the impact of childhood abuse experiences on survivors' ability to find positive adaptation through adulthood. As such, I thought it might be of relevant interest to your organization. I was wondering if you would be willing to share this survey flyer and link through your website or any other social media outlets. This survey is confidential and no names or contact information will be collected in connection with the study. Also please feel free to forward this email on to anyone you know who might be interested.

I appreciate your assistance!

Thank you,
Sarah

*Have you or someone you know experienced
abuse or neglect as a child?*

We are conducting a study to help determine the ways in which adults are able to lead healthy, fulfilling lives following childhood trauma. Your participation could help further important research on how to best help survivors of abuse.

If you have experienced any of the following:

- Emotional/Verbal Abuse
 - Physical Abuse
 - Sexual Abuse
- Emotional or Physical Neglect

Please consider filling out a short online survey!

https://udenver.qualtrics.com/SE/?SID=SV_6rOUugW8mdIzkyN

For questions about the survey, please contact
Sarah Cleary at sarah.cleary@du.edu

Thank you!

The Principal Investigator for this study is Sarah Cleary, M.Ed., doctoral candidate in the Counseling Psychology Ph.D. program at the University of Denver. This study has been approved for distribution by the IRB at the University of Denver (#547892-4).