Mutuality and Resilience in a Sample of Adults with Histories of Abuse: A

Relational-Cultural Perspective by Gender and Race/ethnicity

By

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Abstract

The present study explored the relationship between gender, race/ethnicity, mutuality and resilience in a sample of adults with histories of child abuse. Based on the theoretical framework proposed by relational-cultural theory, which argues that the main cause of human suffering is disconnection and disconnection can only be healed through new, growth-fostering connections characterized by mutuality, it was hypothesized that there is a significant difference in mutuality scores for different groups divided by gender and race/ethnicity. It was further hypothesized that mutuality is a significant predictor of resilience and trauma related symptoms. The sample consisted of 118 adults with self-reported histories of abuse and recruited through community announcements. Participants reported demographic information and completed measures of resilience, current symptoms of trauma and perceived mutuality. Results partially supported the proposed hypothesis. Implications of the study and suggestions for further research are discussed.

Table of **Contents**

Table of Figures

DEDICATION

To my family for all the time I took from you in the last ten years. To my son Sam

because being your father is amazing.

Acknowledgement

I have been blessed by having many strong women in my life. My relationships with them have been instrumental in my healing process and in influencing the trajectory of my life. It is to them that I dedicate my work.

The stories about my great-grandmother, Dolores Santos were fascinating. She was widowed young and raised 8 children under what can only be described as the worst of third-world conditions. But her strength was without equal. My grandmother, Arcadia Torres-Santos was just as amazing. I got from her everything I did not get from the rest of the world. My mother, Carmen Gloria Montero inherited some of that strength. She was a single mother of three by the age of 17. She experienced unbelievable trauma and taught me about resilience. As I learn of your life and your experiences I have begun to understand mine.

I was blessed with my wife Shirley Ann Rivera. I can't think of another woman who would put up with my crap for 32 years. She is my all. Everything that is positive in my life is connected to her. She gave me my daughter Charlyn. I feel like I got high when she was born and I still have not come down. Her mere existence makes my life worth living. To top it all, I dedicate all my work to my grandbabies.

Also need to mention all those who through their contact have enriched my life; Eulalia Villagrass (Lala), Awilda Colon, Dr. Samela Abdullah. Finally, I wish to thank Dr. Eubanks. Thank you for your patience and persistence.

Chapter 1: Introduction

Children experience trauma at a very high rate. According to the United States Department of Health and Human Services, the government agency that sponsors the National Incidence Study of Child Abuse and Neglect, the number of reported cases of abuse rose from 9.8 out of every 1,000 children in the mid-1980s to 17 per 1,000 in 2009. Other estimates suggest 1 out of 10 children in the United States suffers maltreatment (Safe Horizons, 2012). There is ample evidence suggesting that childhood trauma results in negative consequences for children (Perry, 2013; Deblinger, Runyon, & Steer 2014; Shultz et al, 2014). The negative consequences of childhood trauma affect many aspects of the abused child's life and may even have negative impact on that child's subsequent generations. For example, trauma experienced in childhood has been associated with a significant increase in risk for suicide (Garnefski & Arends, 1998) and with mental health problems later in life (Fergusson, Boden, & Horwood, 2008; Deblinger et al.,2014). Child abuse and other forms of trauma also has long term repercussions in succeeding generations by affecting parenting styles and reaction to adversity (Roberts, O'Connor, Dunn, & Golding, 2004).

The effects of childhood traumas go beyond the emotional legacy. Recent research (Cicchetti, Rogosch, Sturge-Apple, & Toth, 2010) suggests that early experiences of trauma can change brain functioning and these changes can affect the individual's reaction to later experiences of adversity. These changes in brain functioning (secretion of chemical to manage emotions) and structure (changes in the actual shape of regions of the brain) have also been found to affect the neurological systems designed to help the individual adjust (Perry et al., 2013; Van Der Kolk, 2015).

9

Despite these risks, many children escape the negative consequences often associated with the experience of trauma (Gorman-Smith & Tolan, 2003). This process of positive adaptation when faced with negative experiences is known as resilience. The study of what we now know as resilience started in the 1960s and since then, resilience has been studied in relationship to individual characteristics, family functioning, community support and social support, among other factors.

Relational-cultural theory (RCT) introduced the concept mutuality in relationships as a factor associated to positive adaptation. As opposed to social support, which RCT described as a unidirectional process, mutuality is a reciprocal process characterized by mutual empathy and mutual empowerment. The present study examined the relationship between mutuality as used in relational-cultural theory and resilience in a sample of adults who experienced child abuse.

According to relational cultural theory, the main cause of human suffering is disconnection and disconnection can only be healed through new, growth-fostering connections characterized by mutuality (Jordan, 2010). Growth-fostering connections are a fundamental and complex process of active participation in the development and growth of other people and the relationship that result in mutual development (Baker-Miller, 1976). The concept of connection, which is central to the definition of growth-fostering relationships, is both an encounter and a process. Baker-Miller (1976) defines connection as the respectful negotiation of differences and disagreements that foster growth.

The opposite of connection is disconnection. Disconnection is not just the absence of the attributes that characterized growth-fostering relationships, but the

opposite of them. Disconnection is common in relationships. Most disconnections take the form of emphatic failures. When those, regularly occurring disconnections are addressed, they can lead to stronger connections. This happens when a less powerful person is allowed to express his or her anger and hurt, and can lead to a strengthened relational competence.

If the more powerful person fails to listen or responds with invalidation, violence or humiliation, the less powerful person stops representing themselves fully in the relationship and the relationship is weakened. Trauma, an extreme form of disconnection, creates a disruption in one's experience of relatedness (Jordan, et al., 2004). RCT refers to the type of disconnection experienced in trauma as chronic disconnection. Trauma is a complete disruption in the way the individual makes sense of his or her world and impedes growth in relationships.

According to RCT, chronic disconnection is healed through new, growth-fostering connections (Jordan, et al., 2004). RCT is grounded in the concept that healing takes place in the context of mutually empathic, growth-fostering relationships (Comstock et al., 2008). Growth-fostering relationships are characterized by mutuality and result in a sense of zest, clarity about oneself, the other and the relationship, a sense of personal worth, the capacity to be creative and productive and the desire for more connection. The role of mutuality in resilience has not been well explored in the research literature.

The remainder of this chapter presents an overview of the project and the theoretical framework that is at the core of the research question. This includes a general

summary of the theoretical framework behind relational-cultural theory and the current understanding of resilience.

Problem Statement

Despite the risks posed by child trauma many children who experience such trauma develop into resilient adults. Relational-cultural theory explains this phenomenon by arguing that the main cause of human suffering, including trauma, is disconnection and disconnection is healed through new, growth-fostering connections characterized by mutuality (Jordan, 2010). However, the role of mutuality in the development of resilience has not been well explored in the research literature. In fact, very few researchers have attempted to explore the relationship between mutuality and resilience. Jordan argues that "Although mutuality is an important relational dimension, few researchers have examined the specific elements that contribute to mutuality" (pp. 68). Hartling (2010) also identified the need for research that explored the relationship between mutuality and resilience.

Purpose of Study

Relational-cultural theory suggest that:

- The main cause of human suffering is disconnection and disconnection can only be healed through new, growth-fostering connections characterized by mutuality (Jordan et al. 2010).

-Men and women have different patterns of relationships (Baker-Miller, 1976)

-Ethnic groups differ in their understanding of relationships, their pattern of

relating, their understanding of connection, and the pattern for seeking

professional help (Bryant-Davis, 2005; Grossman, et al., 2006).

If mutuality has the impact on resilience proposed by RCT, individuals, in this

case adults, who have experienced disconnection in the form of abuse and have overcome

the negative effects expected to result from the abuse, should have also experienced

mutuality in relationships. Also, if men and women have distinct styles of relating, then

there should be a difference in perceive mutuality, level of resilience and trauma

symptoms across gender. And, if, ethnic groups have different social norms and ways of

responding to trauma, then there should be a difference in perceived mutuality, level of

resilience, and trauma symptoms across racial/ethnic groups (Caucasians, African

Americans, Middle Eastern and Latinos).

Research question:

-Does perceived mutuality predict resilience among adult victims of child abuse?

-Does perceived mutuality impact reported symptoms of trauma among adult

victims of child abuse?

-Do adult men and women who were victims of child abuse report differences on

measures of perceived mutuality, resilience and trauma symptoms?

-Is the relationship between perceived mutuality on resilience impacted by gender

or race/ethnicity?

Hypothesis:

Based on the assumptions made by relational-cultural theory, the following hypotheses are tested:

1.   There is a significant difference between men and women on perceived mutuality, level of resilience, and trauma symptoms.

2.   There is a significant difference between Latinos, African-American and Caucasians on perceived mutuality, level of resilience, and trauma symptoms

3.   There is a significant interaction between different categories of gender and race/ethnicity on perceived mutuality, level of resilience, and trauma symptoms.

4.   Reported symptoms of trauma, mutuality, gender, and race/ethnicity will predict resilience.

5.   Perceived mutuality, resilience, gender, and race/ethnicity will predict symptoms of trauma.

Definition of terms:

-Resilience: Resilience involves positive adaptation to negative or traumatic events (Grossman, Sorsoli, & Kia-Keating, 2006; Masten & Coatsworth, 1998). Luthar (2003) argues that resilience refers to a pattern of positive adaptation in the context of significant risk. She continues to argue that resilience requires both aspects of the definition; a pattern of positive adaptation and the experience of significant risk. Resilience is concerned with what is going well when adversity is faced. Curtis and Cicchetti (2003) argue that resilience is a dynamic developmental process reflecting

evidence of positive adaptation despite significant life adversity. They also describe it as a hypothetical construct that must be inferred from an individual's manifestation of competent functioning. Resilience is not a personal characteristic, but rather a general pattern of responding. Curtis and Cicchetti et al. (2003) argue that resilience is not an individual child attribute functioning in isolation, but rather a phenomenon. Others interpret the concept as a complex interaction between the individual and his/her environment (Curtis & Cicchetti, 2003; Masten & Coatsworth, 1998).

-Mutuality: Mutuality refers to "a fundamental property of healthy, growth-enhancing connections". It is a process in which the contribution of each person in the relationship and their openness to change allows something new to occur in the individual and the relationship. According to relational-cultural theory, mutuality is a central characteristic of growth-fostering relationships. Relational-cultural theory posits that humans grow through and towards relationships. Growth-fostering relationships are characterized by mutuality. As a concept, mutuality is measured as a perceived construct within a relationship. Therefore, in the present study we use the term "perceived mutuality" to refer to the scores on the selected measure of mutuality.

-Relational-cultural theory: a relational theory that developed out of the framework of feminist theories of development through the work of Jean Miller (1976) proposes that healing from trauma occurs in the context of growth producing relationships characterized by mutuality.

-Child Abuse: For the purpose of this study, child abuse was defined by participants and self-reported. The definition of child abuse was then based on the subjective experience and interpretation of each participant rather than an objective

standard to which to compare the reported experience. As such, if a participant

considered their childhood experiences as meeting the criteria of abuse, then that

interpretation was accepted as such.

Theoretical Framework

Relational-cultural theory grew out of the work of Jean Baker-Miller (Baker-

Miller, 1976). It is a relatively new theory and as such has seen significant development

in a short period of time. Originally, RCT developed in the context of and in opposition

to psychodynamic theories, particularly self-psychology. While self-psychologist argued

that the ultimate goal of development was a self that was independent, RCT or self-in-

relations theory as it was originally known argues that the goal of development was

interdependence. Also, the original versions of the theory was presented as a theory of

women's development. Theorist argued that the accepted psychological theories of the

time presented a developmental trajectory that was representative of how western society

viewed the development of men.

As the theory developed, theorist proposed not only a change in name (from self

in relations to relational-cultural theory) but also a change of scope (from a theory of

women's development to a theory of human development). According to RCT the need

for connection is a universal need best met through growth-fostering connections

characterized by mutuality. RCT argues that there is a basic human need to turn to others

and to provide support to others. The goal of human growth is to be in relationships and

the way of obtaining that goal is through relationships. In other words, people grow

through and towards relationships. Another way of understanding this is to say that

human are designed to be social and to be in relationships and the way to improve our capacity to be in relationships is by experiencing relationships.

The concept of "connection" is central to the definition of growth-fostering relationships. Connection is both an encounter and a process defined as the respectful negotiation of differences and disagreements that foster growth (Baker-Miller, 1976).

The opposite of connection is disconnection or a rupture in relationships. Disconnection is the main cause of human suffering. Trauma, an extreme form of disconnection, creates a disruption in a person's experience of relatedness (Jordan, Hartling, & Walker, 2004) and impedes growth in relationships. According to RCT, the capacity for relationship and interdependence is the agent for healing,

Growth-fostering relationships are defined as a complex process of active participation in the development and growth of other people and the relationship that results in mutual development (Jordan, et al., 2004). The type and shape of relationships are affected by many personal and social factors. Of interest in the current research are the differences across gender and race/ethnicity on perceived mutuality.

Gender, Relationships, and Resilience

Relational-cultural theory is predicated on the belief that men and women have different patterns of relationships (Baker-Miller, 1976). Although in recent years RCT theorists have argued that the need for connection is universal, most continue to assert that connections are different for men and women (Jordan, 2010).

Consequently, one would expect to find significant differences on the report of perceived mutuality for men and women. Men and women have different experiences in relationships, women are more likely to report distress and men are less likely to seek

17

professional help (Grossman, et al., 2006). Therefore, one would expect that men in the proposed research sample would score lower than women on the measure of perceived mutuality.

Race/ethnicity and Relationships

Differences across ethnic/racial groups have been well documented in the literature (Priest & Nieves, 2007). Research has found that ethnic/racial groups differ in their understanding of relationships, their pattern of relating, their understanding of connection, and the pattern for seeking professional help (Bryant-Davis, 2005; Grossman, et al., 2006). One would expect that those who identified themselves as Latino, Middle Eastern or African American will score lower than White on the measure of perceived mutuality. It is theorized that these lower scores are, in part, explained by a different perception of relationships and the limited availability of Ethnic/racial identical mentors and professional resources.

The understanding of classifications of race and ethnicity in the United States has changed over the centuries. Since the 1790s, the census of the population in the United States have included categories of race. Currently, the racial and ethnic categories used in the census follow the guidelines of the U.S. Office of Management and Budgets. These guidelines require that race and Hispanic origins be considered and collected as separate information. The 2010 census recognizes two ethnicities: Hispanic or Latino and Non-Hispanic or Latino (Census Bureau, 2010).

On the question of race, the census includes many classifications including White, Black or African American, American Indian or Alaskan Native, Asian Indian, Chinese, Filipino, Japanese, Korean, Native Hawaiian, Guamanian or Chamorro, Samoan, Other

18

Asian, Other Pacific Islander, and some other race. According to the census Bureau, these racial categories are not an attempt to establish biological races. These categories of race are supposed to generally represent a social definition of race recognized in the United States and not an attempt to define race as biology, anthropology, or genetics (Census Bureau, 2010).

The census does not recognized Hispanic or Latinos as a race. The census classifies Hispanics or Latinos as an ethnicity. Hispanic or Latinos can be of any racial category. The most recent census questions allow individuals to self-identify their racial background. Latinos that identify a racial background that do not fit the preset racial categories described above are grouped under the category of Some Other Race. Most commonly, these are Latinos that identify themselves in the race question by nationality such as Puerto Rican or Guatemalans. During the 2010 census 36.7% of Latinos fell under this category. According to the Census Bureau, data on race is collected to be used in making federal policy decisions, to promote equal employment opportunities, and to assess racial disparities in health and environmental risk. Inappropriate classification for Latinos may lead inappropriate representation in federal policy discussions.

To address the possible misclassification of racial categories for Latinos, the Census Bureau launched the Alternative Questionnaire Experiment in 2012. Their goal was to improve the race and Hispanic origin question by testing several different questionnaires. At least one of the alternative questionnaires places Latinos as a race in the same way other races are classified. The recommendation from the initial study was to continue to test the combined race and Hispanic origin question in order to improve detail reporting by Hispanics (Census Bureau, 2012).

In the same review, focus group findings suggested the need to add a racial category for Middle Eastern, North African and Arab. This would be a new category.

As with the Census Bureau, we were concerned with how subjects self-identified. We listed the ethnic categories based on the definition of race and ethnicity. The term race refers to the concept of dividing people into groups based on a set of physical characteristics. Ethnicity refers to groups of people classified based on nationality or shared cultural traditions (Hiebert-Meneses, 2007). Because of the size of our sample and the difficulties obtaining a more racially specific sample, we opted to use general ethnic classifications. Latinos, African Americans, White, Middle Eastern. For the remainder of the document we will refer to these classifications as ethnic/racial.

Also, one of the Ethnic/racial groups used in the study is Latinos. For the purpose of this study we will use the term Latino rather than Hispanic. Hispanic refers people whose ancestry comes from a country where Spanish is spoken. Latino refers to a geographical region, specifically Latin America.

Importance of the Research

The current research adds to the literature on RCT. Jordan (2010) one of the pioneers of RCT argues that "Although mutuality is an important relational dimension, few researchers have examined the specific elements that contribute to mutuality" (pp. 68).

The results of this research can help inform interventions to assist in the resilience process for individuals who experienced trauma. Researchers argue that "a compelling rationale for the systematic study of naturally occurring resilience was to inform practice,

prevention, and policy efforts directed towards creating resilience when it is not likely to occur naturally" (O'Dougherty & Masten, 2005; O'Dougherty-Wright, Crawford, & Sebastian, 2007, pp. 31). They further argue that "only by identifying the multifaceted processes underlying successful adaptation under adverse condition will we find ways to intervene successfully in the lives of those who remain vulnerable" (pp. 32). By understanding the relational factors that promote resilience, we can learn to enhance positive outcomes for children who would otherwise suffer the negative consequences of trauma.

For example every year between 400,000 and 500,000 children are in foster care. These children usually experience negative outcomes. According to a report by Child Trends (2015) on children aging out of the foster care system, 38% have emotional problems, 50% have used illegal drugs, 25% were involved in the legal system, and only 48% complete high school.

These children also experience disruptive and unstable relationships. In addition to the disruption in the relationship with their primary care giver that led to the foster care placement, foster care children average 3 placements during their average 31 month stay in foster care (Administration of Children and families, 2014). These children often have to work with multiple case workers and therapist. The department of Health and Human Services reports that the turnover rate for foster care case worker is 20% per year.

By understanding aspects of relationships that promote resilience, we can improve the outcomes for the most vulnerable children. The results of the current study can help identify factors that contribute to resilience and thus assist in developing interventions to enhance those factors. By testing the assumptions regarding the hypothesized

characteristics of growth-fostering relationships in resilient individuals with histories of abuse we can learn to create those relationships for vulnerable individuals when those relationships do not occur naturally. If the results from the study support the theory that growth-fostering relationships characterized by mutuality are an essential component of healing among adults with histories of child abuse, then promoting and enhancing these types of relationships among children who have experienced abuse is a promising programmatic goal.

Overview of methods

To test the hypothesis outlined above, the researcher collected information from 118 adults with reported histories of abuse. Following approval from the Institutional Review Board, participants were recruited using community announcements. Each participant provided demographic information and completed scales that measured resilience, current trauma symptoms, and perceived mutuality. The collected data was then analyzed through a number of Factorial Multivariate Analysis of Variance and Multiple Regression Analysis.

Delimitations

As with any study, the researcher made choices designed to focus the topic and make the task manageable. First, the study was conducted in a mid-size, Central Pennsylvania community. The characteristics of this community may not be similar to that of a national sample. This decision was made because of the location of the researcher. A more geographically diverse sample was out of the scope of the current project.

Also, participants were allowed to subjectively determine if their experiences represented abuse. As such, the experiences of abuse that qualified an individual to participate in the study varied significantly.

Most importantly, the researcher chose to conduct the study with a sample of adults. It was expected that a sample of adults will have had the time to experience the type of relationships described by relational-cultural-theorist.

Limitations

The findings of this study need to be understood as exploratory. Given that this is a retrospective study (participants were asked to report on past experiences) and based on self-report measures, participant's current situation may impact their perception of past events. It is possible that participant would select recent or more intense relationships rather than the ones that most influence their healing process.

The very nature of resilience is a limitation for our study. Resilience refers to competent functioning at a point in time. Resilience changes based on time and situation. Also, the factors that affect resilience at one point in life may change and become more are less beneficial. As such, interpretations beyond the specific circumstances of the study sample at the time of the study need to be done with caution.

There are two inherent bias. First, the sample is a non-probability sample which suggests that it is not representative of the population. Second, being a self-selected sample resulting from a general recruitment effort suggests that those who responded have certain characteristics that may not be present in the population.

Summary

The current study explored the relationship between gender, race/ethnicity, mutuality and resilience in a sample of adults with histories of child abuse from the framework of relational-cultural theory. The study adds to the understanding of the role of mutuality in the healing process for adults with histories of childhood abuse. By testing the assumptions regarding the hypothesized characteristics of growth-fostering relationships in resilient individuals with histories of abuse we can learn to create those relationships for vulnerable individuals when they do not occur naturally.

Chapter 2: Literature Review

As discuss earlier, children who experience childhood trauma tend to develop into resilient adults. For the last fifty years researchers have attempted to uncover the factors that influence this positive adaptation among children who experience trauma. The research during the last fifty years has found that resilience is associated with characteristics of the individual such as likability and high IQ, characteristics of the family, such as family support and cohesiveness, characteristics of the community such as level of support and stability and characteristics of the situation such as severity of the trauma. To this conversation regarding the factors that influence positive adaptation in the face of adversity, RCT adds the concept of mutuality. RCT theorist see not social support or individual, family or community characteristics as leading to growth in those who have experienced trauma. Instead they suggest that resilience is enhanced by participation in growth-fostering relationships characterized by mutuality. The present study examined the relationship between mutuality and resilience in a sample of adults who experienced child abuse.

For the purpose of this project we explored the literature related to resilience and relational-cultural theory. In presenting the theoretical framework we took a funnel approach presenting a look at the theoretical approach and moving towards focusing on the particular theory. This means that for the presentation of relational-cultural theory, we will first present information on attachment theory and then move towards relational-cultural theory.

Resilience

The emphasis on individuals who function well in spite of adversity is traced back to the research of Farina, Garmezy, Zalusky, & Becker, (1962). While studying children of schizophrenic parents, the researchers noticed that most of the children exhibit a higher level of functioning than was expected based on their negative experiences. His curiosity gave birth to the study of positive adaptation when faced with adversity.

According to O'Dougherty-Wright and Masten (2005), research on resilience has occurred in three waves. The first wave focused on identifying individual resilience and factors that make a difference in a resilience adaptation. The factors that have been identified as correlates to resilience are classified as risk factors (those factors that hinder resilience) and protective factors (those factors that promote or facilitate resilience) and are further classified as individual, family or environmental factors. According to the Surgeon General's Report on Mental Health ("US Surgeon General releases report on mental health: culture, race, and race/ethnicity," 2001), general biological factors that affect children's mental health include intrauterine exposure to alcohol, cigarettes and other drugs, exposure to lead, and prenatal malnutrition. Psychological factors include environmental difficulties such as poor or unstable housing, overcrowding, and exposure to violence. In addition, the relationship to primary care givers, parental mental illness, and parental depression are also identified as risk factors for children. And finally, other stressful or traumatic life events such as sexual or physical abuse are seen as potentially risky.

Masten and Coatsworth (Masten & Coatsworth, (1998) described the characteristics of resilient children to include good intellectual functioning, appealing,

26

sociable and easygoing disposition, self-efficacy, self-confidence, high self-esteem, talents and faith. They also argue that resilient children have certain family characteristics that include close relationships with caring parental figures, an authoritative parent, warmth structure, high expectations and connections to extended supportive family network. Bonds with pro-social adults outside of the family, connections to pro-social organizations and attending effective schools are also discussed as environmental characteristics of resilient children.

The second wave of research according to O'Dougherty-Wright and Masten (O'Dougherty & Masten, 2005) "attempted to explore moderating processes that would explain protective effects" (pp. 26). The goal is twofold: first to explain how these protective factors work and then to explain the possible interaction among protective or risk factors.

The third wave focuses on interventions designed to promote resilience when resilience is not likely to occur naturally (when it is available in the individual's environment and occurs with minimal effort). This wave of research is in its infancy. The present research falls within this area of research.

Masten and Wright (2009) added a forth wave in the study of resilience. The studies in this wave look at the biological/molecular components of resilience. Researchers have found that trauma negatively impact the development of brain structure (Sohye, Fonagy, Allen, and Strathearn, 2014; Van Dam, Rando, Potenza, Tuit, & Sinha, 2014). The functions performed by those underdeveloped or impacted structures also become affected (De Bellis, Zisk, 2014). Trauma impacts the functioning of the brain by changing chemical reactions and by doing so, affecting the individual's ability to manage both typical life events and other

27

stressful situations (Sadeh et al., 2013; Weed, Morales, & Harjes, 2013; Liu et al., 2015). Trauma

affect the parts of the brain that regulate emotions, attachment, relationships, arousal and

responds to stress (Perry and Sullivan, 2014).

Definition of Resilience

Resilience refers to the process of positive adaptation when faced with adversity.

Luthar (2003) states that resilience refers to a pattern of positive adaptation in the context

of significant risk. She continues to argue that resilience requires both aspects of the

definition; a pattern of positive adaptation and the experience of significant risk. This is

the definition of resilience which will be used in this dissertation research.

Early in the history of research on resilience it was believed that resilience was a

personal characteristic of individuals. Children who exhibited resilience were thought of

as hardy or invulnerable. Recent research has provided a different understanding of

resilience. Curtis and Cicchetti (2003) argue that resilience is a dynamic developmental

process reflecting evidence of positive adaptation despite significant life adversity. They

also defined resilience as a hypothetical construct that must be inferred from an

individual's manifestation of competent functioning. Curtis and Cicchetti (2003) argue

that resilience is not an individual child attribute, but rather a phenomenon a complex

interaction between the individual and his/her environment.

The definition of resilience involves both risk and competence. Masten (2001)

states that "risks are actuarially based predictors of undesirable outcome" (pp. 230)

(Masten, 2001). Risks range from status variables to direct measures to exposure to

maltreatment or trauma. Status variables refer to a status or state of being that has been

empirically associated with negative outcome. Examples include poverty and parental

mental illness. Direct measures of maltreatment or trauma refer to exposure to specific

measurable events or series of events that have been empirically associated with negative

outcomes. Examples include a specific trauma such as abuse (Goldstein & Brooks,

2004).

Risk is co-occurring. Although there are particular risk factors that can occur in

isolation, for example, being the victim of a crime, most risk factors, like child abuse,

occur in conjunction with other risk. Furthermore, risk tends to facilitate exposure to

other risk. For example, poverty often occurs with unstable housing, exposure to

violence, and poor educational experiences (Vanderbilt-Adriance & Shaw, 2005).

Because risk is co-occurring, it is often difficult to isolate one risk factor to study.

The definition of competence is crucial in the understanding of resilience. Luthar

and Burack (2000) define competence as "the individual success at meeting major

societal expectations relevant to their particular stage of development" (pp. 30). Masten

and Coatsworth (1998) define competence in a similar way, that is, a pattern of effective

adaptation in the environment. They also argue that competence results from a complex

interaction between the child and the environment. The assessment of competence varies

depending on social context, age, and developmental task and as suggested by Luthar and

Burack (2000), the perception of the evaluator. Masten (2001) argues that the assessment

of competence involves an inference or a judgement regarding performance. Masten

(2001) further argues that definition of competence continues to be debated. She states

that some define competence as " an observable track record of meeting the major

expectations of a given society or culture in historical context for the behavior of children

of that age and situation" (pp. 229).

Relational-Cultural Theory

Relational-cultural theory is both a theory and a treatment model. The model grew out of the work of Jean Baker-Miller originally published in 1976. The ideas outlined by Baker-Miller can be traced back to postmodern thinking that challenged the ideas of traditional theories and universal truths. Relational-cultural theory grew from the belief that traditional psychological theories of development with an emphasis on separation and individualization were inadequate in explaining the development of women. According to Jordan (2010), "western psychological theory tends to depict human development as a trajectory from dependence to independence." (pp. 1).

She further argues that these models use concepts such as autonomy, individualization, self-boundaries, separation and the increased use of logical thinking as markers of maturity and growth. Jordan and Dooley (2000) argue that this idea of separateness came from an attempt to make psychology a science. They further argue that to be legitimized as a science, psychological theorists modeled their ideas after Newtonian physics. The tendency of Newtonian physics to emphasize objects as discrete and separate and acting on each other in ways that are predictable led to the formulation of the concept of "the self" as a "molecular entity" with a separate identity. The self is seen as occupying space and having a center and external boundaries. To follow the model of Newtonian science, the self then seeks to separate. Jordan (2010) argues that in most models of psychology the self is seen as functioning best when it has a strong containing boundary that maintain separation.

Baker-Miller (1976) argued that women's pattern of relating is different and these traditional models of psychological theories with their emphasis on independence

30

pathologized the way women relate. While traditional models of development focused on individualization, the cultural focus of women has been on interdependence and relationships. Women's psychological development with its theorized emphasis on relationships and connections is not a lesser model than traditional models. According to RCT, the relational model is a better measure of human development. Interdependence is a sign of maturity rather than independence. RCT proposes that people grow through relationships, that mutual empathy is at the core of growth-fostering relationships and that authenticity is necessary for real engagement in relationships (Jordan & Dooley, 2000).

Relational-cultural theory emerged as a feminist view of functioning and in the original writings positioned itself in juxtaposition to what the writers considered male dominated models. However, the ideas promoted by RCT have gained a foothold among recognized theories of personalities and some argue for the universality of relational concepts. According to RCT, the need for connection is a universal need best met through growth-fostering connections characterized by mutuality (Baker-Miller & Stiver, 1997). Others have argued that the developmental emphasis on individuality, aloneness, and competition placed on boys within western society robs them from an essential human need to connect (Dooley & Fedele, 2004).

Theory of Illness and Cure

Like most theories of psychology, relational-cultural theory addresses general psychological health and illness. RCT argues that there is a basic human need to turn to others and to provide support to others. The goal of human growth is to be in relationships and the way of obtaining that goal is through relationships. In other words,

31

people grow through and towards relationships. The ideal is for people to be in growth-fostering relationships. Growth-fostering relationships start at birth. The infant is connected with the mother and their relationship is naturally mutual; the infant impacts the mother and is impacted by her. This mutually empathic relationship provides the foundation and a model for future growth-fostering relationships.

The ideal relationship is one where all involved are engage in the growth of the other. Growth-fostering relationships are defined as "a fundamental and complex process of active participation in the development and growth of other people and the relationship that results in mutual development". The measure of success for a growth-fostering relationship is that it leads to zest, sense of worth, clarity, productivity, and a desire for more connection (Baker-Miller, 1976).

The concept of "connection" is central to the definition of growth-fostering relationships. Connection is both an encounter and a process. It involves being in mutually empathic relationships that produce mutual growth. Connection is the respectful negotiation of differences and disagreements that foster growth (Baker-Miller,1976).

The opposite of connection is disconnection. Disconnection is not just the absence of the attributes that characterized growth-fostering relationships, but the opposite of them. Disconnection is an empathic failure in relationships. Disconnections are common in all relationships but how those failures are resolved would determine their impact. RCT recognizes two categories of disconnection. Acute or short term disconnections are common in relationships and can work as an opportunity to further relationships. Particularly when a less powerful person is allowed to express his or her anger and hurt, this can lead to a strengthened relational competence. Because

disconnection often happens between individuals with different levels of power, rewriting of the disconnection experience by experiencing the characteristic of growth-fostering relationships, is considered an act of social justice.

However, when disconnection does not allow the less powerful person to express his or her anger and hurt, the disconnection becomes chronic. Chronic disconnection can lead to shame, fear, frustration, humiliation and sense of self-blame (Jordan & Dooley, 2000). Disconnection can lead to condemned isolation, or the experience of isolation that leaves the person shut out of connections and human community (Baker-Miller & Stiver, 1997). This experience leads individuals to a sense of shame and the belief that they are defective. In an attempt to connect, individuals hide part of themselves and connect with others in an inauthentic way through non-mutual relationships. RCT theories refer to this coping strategy as "the central relational paradox".

Relational-cultural theory and trauma

According to relational-cultural theory, trauma is an extreme form of disconnection that creates a disruption in one's experience of relatedness (Jordan, et al., 2004). Trauma is a complete disruption in the way the individual makes sense of their world. Trauma impedes growth in relationships. According to Jordan (Jordan, et al., 2004), the victim of trauma loses even the hope that there can ever again be a fully emphatic, loving relationship with another person.

The disconnection resulting from trauma is healed through new, growth-fostering connections. According to RCT, not only is the capacity for relationship and interdependence a measure of psychological maturity, it is also the agent for healing.

According to Comstock et al. (2008), RCT is "grounded in the idea that healing takes place in the context of mutually empathic, growth-fostering relationships" (pp. 279).

Relational-cultural theory and the therapeutic Process

Like most psychological theories, RCT proposes a theory of illness (what can go wrong) and a theory of cure. RCT assumes that people grow through and towards relationships (Jordan & Dooley, 2000). Relationship is the process and the goal of human development (Walker, 2004). Psychological health and development is a function of participation in relationships in which mutual empowering connections occur. The basis for change in relational-cultural therapy is the relationship between the client and the therapist and not any specific therapeutic technique (Jordan, 2010). The approach to therapy is described more as a world view or philosophical approach rather than a technique (Walker, 2004). Walker continues to argue that therapy in the RCT model is based on the idea that:

- Relational differentiation and elaboration characterizes growth.
- Mutuality and shared power are signs of mature functioning.
- Mutual empathy is an essential process in effective therapies
- Therapeutic authenticity is necessary for the development of mutual empathy.

The goal of therapy is to increase the capacity for resilience and empower the client to move towards connections. Through the relationship between the therapist and the client the therapist seeks to lessen the experience of disconnection. This occurs through a flow of connections and disconnections in the therapeutic relationship and in the client's life. Through mutual empathy, the relationship is safe and allows the client to

34

move towards engagement in growth-fostering relationships. In the context of a therapeutic relationship the client and the therapist explore, challenge and change the relational images that guide the client's relationships. Relational images are patterns of relationships that develop through relational experiences and that guide the client's current relationships.

In therapy the therapist and client negotiate a complex relationship. Initially, the goal of the interaction is to form a safe relationship (Jordan, 2010). According to Jordan & Dooley (2000), the therapist's emotional presence is an important source of information for clients and a resource for growth in the therapy relationship. The authors argue that relational authenticity is not the same as total honesty on the part of the therapist. It is important for clients to develop an awareness of the impact of their actions and words on other people and on relationships.

The process of relationships in therapy is similar to the process of relationship in life. Within the ethical boundaries of the profession, the relationship within therapy mimics the model of a growth-fostering relationship in life. In fact, authenticity in the therapeutic relationship is a prerequisite for mutuality. The therapist is not expected to present a different persona or implement a magical technique. The rules and expectations of the therapeutic relationships allows the client to experience a model of relationship that can be experience in life. Also, the aspects of the therapeutic relationship that are considered growth producing are the same for any other relationship. In therapy and in life growth-fostering relationships are characterized by mutuality which is made up of mutual empathy and mutual empowerment.

Mutuality

The movement towards growth-fostering relationships is aided by empathy. Empathy is a complex cognitive-affective skill that involves the ability to join with another in their experience (Jordan, et al., 2004). Empathy is a staple of many therapeutic approaches. However, RCT takes empathy a step further. In RCT the curative factor is not just empathy, it is mutual empathy. Mutual empathy refers to the understanding that the therapist can take in the client's experience and that the experience matters in the relationship. Mutual empathy requires the therapist to move information about their responses to the client into the relationship (Walker, 2004).

According to Relational-cultural theory, mutuality is a central characteristics of growth-fostering relationships. Although relationships are essential to human growth and healing, not all relationships are growth-producing. According to RCT, growth-fostering relationships are defined as process of active participation in the development and growth of other people and the relationship that results in mutual development.

Mutuality is a creative process in which the contribution of each person in the relationship and their openness to change allows something new to occur (Surrey 1991). This something new is growth in all the individuals participating in the relationship. When people participate and contribute to growth fostering relationships, all involved grow. The realization of increased relational competence is the goal of development.

Mutuality does not assume sameness. On the contrary, relational-cultural theory recognizes the existence and need for separation via hierarchy, boundaries, or power. The child is not the same as the parent. Their responsibility and authority is different.

However, even with these differences and boundaries, the relationship affects and impacts both or all involved and lead to positive changes to everyone in the relationship.

Mutual empathy

The concept of empathy is also redefined in RCT. Most theorist, including those within the RCT movement will agree on the basic definition of empathy offered by Schafer (1959). Shafer defined empathy as the internal experience of sharing in and understanding the momentary psychological situation or state of other people. Relational-cultural theory argues that empathy as used by object relational theorist refers to an affective process involving a temporary breach of ego boundaries. They also argue that in Rogerian theory, empathy is unidirectional; the therapist is empathic. In redefining empathy, RCT argues that empathy does not involve loss of identity and instead it is a complex and developmentally advance interactive process. RCT suggest that empathy requires a well-defined sense of self and a sensitivity to the differences and sameness of the other person (Jordan, Surrey, and Kaplan, 1991).

To Roger's use of empathy, RCT adds the idea of mutuality. In RCT, empathy is valued as a reciprocal process in which all involve in the relationship participate in the empathic relationship. In this process in which empathy flows in both directions, there is an intense sense of self as part of a relational unit. This leads to empathy attunement which refers to the capacity to share in and understand the momentary psychological state of the others in the relationship (Jordan, Surrey, and Kaplan, 1991).

According to Miller and Stiver (1997) mutual empathy as a joining together based on the authentic thoughts and feelings of all the participants in a relationship. Mutual empathy creates the flow and exchange that leads to growth. Miller and Stiver (1997)

argue that "Because each person can receive and then respond to the feelings and thoughts of the other, each is able to enlarge both her own feelings and thoughts and the feeling and thoughts of the other person. RCT suggests that empathy starts with a motivation for human relationships that allows one to perceive and understand the others emotional cues. This is followed by the perception of this cues as if they were ones owns (Jordan, Surrey, and Kaplan, 1991).Simultaneously, each person enlarges the relationship (pp. 29).

Mutual empowerment

Mutual empathy leads to mutual empowerment. Mutual empowerment is defined as a two way dynamic process that results from participation in responsive, mutually empathic relationships (Hartling, 2010). Hartling (2010) further states that "mutual empowerment a sense that both (or all) people in the relationship have the ability to influence their experience and the relationship, and are able to take action on behalf of themselves and others." (pp. 59)

Relational resilience

As they do with developmental theory, RCT tries to redefine the understanding of resilience from what they call a focus on individual factors that promote resilience to what they refer to as relational resilience. RCT starts with the idea that "residence is all about relationships" (Harding, 2010 pp.51). Building on the work of Jordan (2004), and others, Harding (et, al. 2010) argues that relationships are a primary source of an individual's ability to be resilient. Also, she argues that relationships provide experiences that strengthens characteristics commonly associated with resilience. Growth-fostering

relations are also resilience strengthening relationships. These relationships are constructed within and define by social context and social context facilitates or impedes the development of such relationships. Resilience is then defined as "the ability to connect, reconnect and resist disconnection in response to hardship, adversity, trauma, and alienating social/cultural practices (Hartling 2010, pp 54). This ability is not an individual characteristic possessed by particular people but a skill that can be developed through involvement in growth fostering/resilience strengthening relationships (Jordan, 2004).

Research on Relationship Theory

The arguments made by relational-cultural theory regarding the importance of relationships in the process of human development appears to be supported by the available research literature. Since the original research on attachment, the role of relationships in adjustment has been recognized, but not always understood. Bowlby (1969) believed that as a result of the relationship with the primary care giver the child eventually develops beliefs and expectations about the reliability of the attachment figure in providing safety and a secure base by internalizing attachment experiences with the caregiver over time. The depth to which the child is able to rely on the attachment figure as a source of safety and security and the child's expectations/beliefs about the attachment figure's trustworthiness based on actual events determines the quality of the early attachment relationship. He referred to these expectations as the child's internal working model of the attachment relationship. The internal working model of attachment contains a model of other and a model of self within relationship to one another. This

attachment is characterized by a reciprocal relationship with the primary caregiver and is instrumental in the development of healthy functioning patterns throughout life.

Since Bowlby's (1969a, 1969b) initial research on attachment it has been understood that relationships with primary caregivers set the stage for future relationship patterns. Other research on relationships suggest that interpersonal connections play an important role in adaptation throughout life. Also, research on positive adaptation support the theory that positive relationships or particular aspects of those relationships can serve as protective factors for individuals dealing with adversity. However, the research on which aspects of relationships work to assist in adjusting to trauma appears to be confusing. While some studies have identified positive relationships and social support as essential to resilience, others have suggested that the impact these and other factors on resilience is mediated by specific characteristics of the experience of adversity or the type of relationship or support. The findings in other studies suggest that the process of adaptation and recovery from the experience of adversity is idiosyncratic. People find unique and creative ways of overcoming difficulties. Relational-cultural theory attempts to add to this discussion by suggesting mutuality in relationships as a key factor in the resilience process.

Sagy and Dotan (2001) explored the resources that may help maltreated children cope with their state and stay well. The moderating variables studied were sense of family cohesiveness and psychological sense of school membership and social support. They found that family coherence was an explanatory variable in explaining the resilient responses of maltreated children. They concluded that for these children regardless of the

40

abuse, the family that is structurally stable, presents clear and consistent rules and deals with problems in a consistent way serves as a source of strength (Sagy & Dotan, 2001).

Williams, Lindey, Kurtz, and Jarvis (2001) explored how some former runaway and homeless youth emerged from their traumatic lives to successfully overcome adversity and adopt resilient life paths. Three of the women were classified in the positive end based on the idea of life trajectory while two of the women were classified in the opposite end or negative live trajectory.

Researchers found four themes related to the development of resilience: determination, meaning and purpose of life, caring for self, and receiving help from others. The researchers concluded that relationships with helping professionals and their spiritual connections were important for all participants. Another aspect of the recovery process identified by participants was learning to trust in safe individuals.

Gall, Basque, Damasceco-Scott, and Vardy (Gall, Basque, Damasceco-Scott, & Vardy, 2007) explored the relationship with God or a higher power in the current adjustment of adult survivors of childhood sexual abuse. The study found that relationship with a benevolent God was correlated with lower anxiety, anger and depressive mood, greater sense of hope and self-reliance, and with survivors ascribing less blame to the perpetrator. A sense of a provident God correlated with degrees of depression and a greater sense of resolution of the abuse. The researchers concluded that the sense of relationship with God or a higher power may serve as a significant predictor factor for sexual abuse survivors. They further concluded that this relationship may represent an important or only source of secure attachment. Having a collaborative relationship with a higher power may be a useful coping resource.

Cecchet and Thoburn (2014) analyzed the narratives of interviews with 6 survivors of child and adolescent sex trafficking in order to assess factors that influenced their ability to survive, leave the sex trade, and reintegrate back into the community. They found that in the survivor microsystem, participants' insecure attachments led to their vulnerability to recruitment; within the mesosystem unsafe relationships contributed to increased emotional insecurities; in the macro system, participants were raised in environments that desensitized them to prostitution. They also found that participants left the sex trade because of pregnancy or mental health symptoms; in this mesosystem, participants needed safe relationships and increased self-worth.

These and other studies support the importance of relationships in the development of resilience. Other studies are more specific and looked specifically at social support and its impact in overcoming adversity.

Hines, Merdinger and Wyatt (2005) explored factors associated with academic success among former foster youth. Using data obtained from in-depth qualitative interviews with 14 former foster youth attending a four-year university at the time of the study. They found that this population was able to identify many factors associated with relationships as important in their recovery or adjustment process. Specifically, participants identified supportive educational systems and teachers, support from the foster care system, and having positive role models.

Banyard and Williams (2007) examined aspects of resilience and recovery for female survivors of abuse and examined the survivor's own narratives about recovery and healing. The study was a longitudinal study that followed 87 women across 23 years. Women were interviewed at three stages over the 23 years. They found that the women

interviewed named social support and external resources in the form of relationships as a factor in their recovery. This support came in the form of specific relationships with individuals or groups.

Marlvate and Ntomchukwu-Madu (2007) examined the effect of levels of social support and type of coping strategies on the psychological adjustment of adult survivors of childhood sexual abuse. Five hundred students from two universities in South Africa participated. Results suggested that higher levels of social support correlated with superior psychological adjustment.

Also, Chamberland, Lacharite, Clement, & Lessard (2014) studied risk factors associated with development in vulnerable children. They found that social support acts as a moderator of child abuse potential and home environment. Nair, James, & Santhoosh (2015) studied identity crisis in adolescents following an experience of abuse. They also found that social support can reduce the effects of abuse by reducing symptoms of identity crisis.

However, the evidence in favor of social support as a protective factor for individuals facing adversity is not universal. For example, Bolen & Gergely (2015) studied the relationship between non-offending caregiver's support and post-disclosure functioning in sexually abused children. They found minimal support for such relationship.

 Also, recent research found that the effects of social support are mediated by variables such as the source of the support, the severity of the abuse, and gender of the victim. Research suggest that there is a different impact on adjustment to experiences of abuse when the support comes from family vs. friends that is also moderated by the type

and severity of abuse (Lamis, Wilson, King, & Kaslow, 2014; Evans, Steel, & DiLillo, 2013; Wilson & Scarpa, 2014). Gender and race/ethnicity also affect the impact of social support. The type of support that is effective in mitigating the effects of abuse for women is different than for men (Teoh at l, 2015: Folger & O'Dougherty, 2013). Also, the type of support and effect of social support has been found to be different for African Americans than Caucasians (Lamis, et al, 2014).

Participants in the study by Glaiser and Abel (2001) provided an explanation of what they understood as helpful type of social support. Glaiser and Abel (et al, 2001) explored the experience of female survivors of abuse. The women reported that support and relationships with therapist, partners, family members, sponsors, ministers, friends, and group members facilitated healing. They further reported that supportive individuals listened without judgment, provided information, understanding and guidance, and shared of themselves. On the other hand, relationships with individuals that were judgmental, provided little or useless information, recommended treatments that were ineffective and did not participate fully in relationships were identified as impeding growth.

Mutuality vs Social Support

Relational-cultural theorists argue that it is not social support but mutuality that serves as a healing agent in relationships. According to Jordan, (Jordan, 2005) the notion of social support studied in relationship to resilience refers to a unidirectional concept. Support tends to go from the adult or the parent to the child. On the other hand, mutuality is the process in which the contribution of each person and openness to change allows for something new to happen (Walker, 2004). Relational-cultural theorists argue

that rather than social support as a unidirectional concept, it is growth-fostering

relationships characterized by mutuality that provides the curative action. When people

contribute to the development of growth-producing relationship, they grow as a result of

their participation in such relationships (Comstock, Hammer, Strentzsch, Cannon, Parson

and Salazar, 2008).

Mutuality and Resilience

As mentioned earlier, the available scientific literature on mutuality is limited, but

also suggest that under certain condition, mutuality can play a positive role in the

recovery process of those affected by child abuse.

Bryant-Davis (Bryant-Davis, 2005) conducted a retrospective qualitative study of

70 African American survivors of childhood violence. Results indicated that

relationships in the form of spirituality or relationship with a higher being, community

support, and therapy.

Kia-Keating, Sorsoli, and Grossman (Kia-Keating, Sorsoli, & Grossman, 2010)

explored the relational challenges and recovery process of 16 male survivors of childhood

sexual abuse. They found that although participants had experienced significant

relational challenges, they had also experienced positive relational experiences and

processes. The researchers described these experiences as "positive, growth-fostering

processes" and defined these growth-fostering processes as "relational process that the

men subjectively described as those that helped them improve, develop in a positive

direction, or heal in some way" (pp. 670). Among the similarities experienced by the

participants are the seeking and accepting connections and giving support to others that

experience personal suffering. In other words, participants identified the experience of giving and receiving support as essential in their recovery process (Kia-Keating, et al., 2010).

Wexler, Jernigan, Mazzoti, Balwin, Griffin, Joule, and Garoutte (2013) explore the strategies used by Alaskan Native youth to cope with lived challenges. They found that the most commonly identified stressors were relationship loss, "not being there for me", non-supportive or hostile experiences, transitioning into adult, and boredom. They also found that resilience strategies included developing and maintaining relationships with others, creating systems of reciprocity, and giving back to family and community.

This concept of reciprocity or giving back by helping others was also part of the recovery process for participants of an earlier study published by the same researchers (Grossman, et al., 2006). Grossman, Sorsoli, and Kia-Keating (2006) attempted to explore how sixteen resilient male survivors of serious childhood sexual abuse, made meaning from their abuse experiences. Three main types of meaning-making styles were identified in the narratives. They included meaning-making through action, using cognitive strategies, and engaging spirituality. Meaning-making through action included helping others. They also found that meaning-making styles seem to be related to experiences with therapy: the more experience these men had with specialized trauma therapy, the more likely they were to make meaning by attempting to understand their perpetrators. However, the study did not explore the aspects of the therapeutic relationship associated with healing. Also, men of color, regardless of socio-economic class, were less likely than Caucasian men to have received specialized trauma therapy, suggesting that their healing relationships occurred in a different context. Again, in this

46

study, the idea of giving back or reciprocating for the support obtained was identifies as a key factor in the healing process. In the few available studies, mutuality as defined by relational-cultural theory has been associated with a variety of component of healing and recovery and with positive psychological functioning among survivors of trauma.

Hedelin and Johnson (2003) explored the experience of mental health and depression in a sample of elderly women with two different qualitative studies. In the first study, sixteen women were asked to narrate their present personal experiences of well-being, a meaningful life and a sense of community. In the second study, five women who were suffering from depression were asked to describe their experience.

Researchers found that when mutuality is perceived, mental health can be interpreted as an ascending spiral characterized by confirmation of value, trust and confidence, zest for life and commitment to further relationship. On the other hand, when mutuality was not evident and the woman's value and self-esteem were violated, the result was a descending spiral characterized by confirmation of worthlessness, loss of self-respect and depression. They concluded that Mutuality appeared to be a significant component in the women's outlook on life.

Neff, Braneck and Kearney (2006) examined relationship styles among a group of Mexican-American and European college students. Participants were recruited from three different universities in Texas. Participants were then asked to review a set of narratives and identify which one best described their interaction in their romantic relationship. The study found that those participants who selected mutuality as their relational style were more likely to perceive their relational style as authentic. The

47

research also found that mutuality participants had significantly better scores on a combined composite measure of psychological health.

Baumann, Kuhlberg and Zayas (2010), studied the relationship between mutuality, internalizing and externalizing symptoms, familism, and suicidality in a group of Latino mother and daughter dyads. They hypothesized that the lower the adolescent's score on the mutuality scale the greater the scores on the measures of internalizing and externalizing symptoms. They found that mutuality was significantly lower for those who had attempted suicide that for those that did not. They also found a larger positive gaps in familism (mother reported scores higher than their daughter's) resulted in lower mutuality scores. They also found a negative relationship between mutuality and externalizing and internalizing symptoms, suggesting that lower scores on perceived mutuality are associated with an increase in symptoms.

Spencer, Jordan, and Sazama (2004) explored young people's descriptions of their experience in and understanding of their relationships with the important adults in their lives using the framework of relational-cultural theory. Group members identified the importance of an adult engaging with them in ways that engender mutuality and respect. Participants stated that they tend to experience this type of connection with adults that genuinely care about them. On the other hand, participants described adults as having difficulties seeing them as equal human beings. They also found that "a key element of mutual respect was the adult's capacity and willingness to allow the child to have a direct and open impact on him or her and to shape their relationship with each other."

The research on the effect of mutuality on resilience is limited and made up mostly of qualitative studies. The present study is one of a few attempts to empirically

explore the relationship between perceived mutuality and resilience. If, as proposed by relational-cultural theory, the main cause of human suffering is disconnection and disconnection can only be healed through new, growth-fostering connections characterized by mutuality, then those adults who have histories of abuse and are currently not suffering from all the negative effects associated with child abuse would have experienced growth-fostering relationships characterized by mutuality at some point in their healing process.

Based on the assumptions made by relational-cultural theory, the researcher hypothesizes that adults with histories of child abuse who score higher on measures of resilience will also score higher on a measure of perceived mutuality in relationships.

Summary

Relationships play a positive role in adjusting to trauma. Few researchers will challenge this statement. However, the particular characteristics of relationships that assist in the healing process, continue to be debated. As some suggest, certain type of support, from certain people at certain times appear have a positive impact. Others have found that the adjustment or healing process is idiosyncratic. People find and take what they need from relationships. Others, like relational-cultural theorist argue that trauma is healed through relationships characterized by mutuality. The current study examined the relationship between mutuality and resilience in a sample of adults with histories of child abuse.

Relational-cultural theory is a relatively new theory that traces its origins to the work of Jean Baker-Miller's landmark book originally published in 1976. Like many

other theories, the literature available falls into two general categories. One is theoretical (explains the history, evolution and beliefs). Within this category one finds the original writings of the founders of the theory and the development of the ideas that are central to the theory. Another part of the theoretical literature includes writings outlining the development and principles of the relational-cultural theory as a treatment or therapeutic model. The second category of literature involves scientific literature that tests the beliefs of the field. Theoretical literature of relational-cultural theory is greater than the scientific literature.

Overall there are many additional questions regarding the role of relationships in the healing process for those who survived trauma. For example, Howell and Miller-Graff (2014) found a positive relationship between resilience and support from friends but not from family. Musiner and Singer (2014) found that the effect of support is affected by the characteristics of the abuse experience. In their study, support was associated with lower levels of depression when the abuse was perpetrated by a non-parent or caregiver. When the abuse was perpetrated by a parent or caregiver emotional support was not associated with lower levels of depression, regardless of who provided the support.

After an extensive review of the literature on RCT several questions remain unanswered. According to relational-cultural theory people grow towards and through growth-fostering relationships. Growth-fostering relationships are characterized by mutuality (mutual empathy and mutual empowerment). RCT defines trauma as a disruption in connection (disconnection) that can only be healed through new, growth-fostering connections characterized by mutuality (Baker-Miller, 1976). Although the role

50

of relationships and social support in protecting trauma victims from the negative effects of trauma and in assisting trauma victims in the healing process has been documented, the role of mutuality has not.

The present study tested this theory in a sample of adults with a history of child abuse. If, as proposed by relational-cultural theory, the main cause of human suffering is disconnection and disconnection can only be healed through new, growth-fostering connections characterized by mutuality, then those adults who have histories of abuse and are currently not suffering from all of the negative effects associated with child abuse would have experienced growth-fostering relationships characterized by mutuality at some point in their healing process. Based on the assumptions made by relational-cultural theory, the researcher hypothesized that adults with histories of child abuse who score higher on measures of resilience will also score higher on a measure of perceived mutuality in relationships.

Chapter 3: Methods

Research Design

The study was retrospective (ask participants to provide information about past life experiences) and exploratory (it explores the relationship between two variables) that explored the relationship between mutuality and resilience. The study explored and inferred the relationship between perceived mutuality, gender, race/ethnicity, and resilience and symptoms of trauma.

- Independent Variables

    • Demographic variables (gender, race/ethnicity) as reported by participants.

    • Perceived mutuality: Total score in The Mutual Psychological Development Questionnaire (MPDQ). Perceived mutuality will serve both as a dependent and independent variable.

    • Current trauma symptoms: Total score on the Trauma Symptom Checklist.

- Dependent Variables

    • Resilience: Overall score on the Resilience Scale for Adults

    • Current trauma symptoms: Total score on the Trauma Symptom Checklist.

    • Perceived mutuality: Total score in The Mutual Psychological Development Questionnaire (MPDQ).

Measures

Demographic information form - Participants completed a demographic information form providing general information regarding their current status including age, race/ethnicity, gender and education and type of abuse experienced as a child. Only data on gender and race/ethnicity will be used in the analysis. (Appendix I). Measures of resilience – Resilience Scale for Adults (Friborg, Hjemdal, Rosenvinge, & Martinussen, 2003).

The Resilience Scale for Adults (Appendix II) is a 33-item scale Items on a Likert scale with each item given a choice from an undesirable answer to a desirable one. Participants use a seven point scale rate themselves between the two extremes. Items 3, 6, 8, 10, 11, 14,15,18,19,22,23,26,28,29,31, and 33 are reversed scored. The scores are totaled for a total resilience score and are organized into 5 sub-scales or dimensions associated with resilience: Personal structure/perception of self, personal structure/perception of the future, structural style, social competence, family coherence, and social resources.

According to the original validating study (Friborg, et al., 2003), construct validity showed significant positive correlations with the scores on the Sense of Cohesiveness Scale and negative correlation with the score on the Hopkin's Symptoms Checklist. Also, initial studies reported a Cronbach's alpha coefficient ranging from 0.63 to 0.90 for each domain. For the current study, the Cronbach's Alpha Coefficient obtained was .92.

Current Trauma Symptoms - Trauma Symptom Checklist – 40 (Elliott & Briere, 1992)

The Trauma Symptoms Checklist-40 (Appendix III) is a 40-item measure used to assess trauma-related problems. According to the author, "The TSC-40 is a research measure that evaluates symptomatology in adults associated with childhood or adult traumatic experiences. It measures aspects of post-traumatic stress and other symptom clusters found in some traumatized individuals." The measure produces six scales: Dissociation, Anxiety, Depression, Sleep Disturbance, Sexual Problems, and a Sexual Abuse Trauma Index. Each item is rated according to its frequency of occurrence over the prior two months, using a four-point scale ranging from 0 ("never") to 3 ("often"). In the studies that have used the scale, subscale alphas have ranged from 0.66 to 0.77 (Koopman, Gore-Felton, Classen, Kim, & Spiegel, 2001). For the current sample, Cronbach's Alpha Coefficient obtained was .88.

Predictive validity for this scale was tested by Whiffen, Benazon, and Bradshaw (1997). They found that the scale is effective in descreminating between those who were sexually abused and those who were not. Elliott and Briere (1992) examined the usefulness of the Trauma Symptoms checklist-40 in measuring the long-term sequelae of sexual abuse. They found that women who reported sexual abuse scored significantly higher than those who did not. Zlotnick, Dhae, Begin et al (1996) also found that the Trauma Symptoms Checklist-40 distinguished 83% of abuse cases.

Measures of Perceived Mutuality - The Mutual Psychological Developmental Questionnaire (MPDQ) (Genero, Miller, Surrey, & Baldwin, 1992) measures perceived mutuality in close relationships (Appendix IV). According to the authors, the measure is based on a psychological model of connection with others and captures the bidirectional

54

nature of relationships. The scale is designed to measure six conceptual dimensions of mutuality: empathy (shared flow of thoughts and feeling), engagement (focusing on one another), authenticity (knowing and sharing each other's experiences), zest (energy releasing quality of relationships), diversity (working through different perspectives and feelings), and empowerment (action by which each person has an impact on the other in the relationship. The scale contains 22 items. The first eleven items explore participants' self-reported responses. The last eleven items ask participants to rate the other person's expected responses. Ratings in the scale are made on a six-point Likert scale ranging from never to all the time. Higher scores indicate greater levels of perceived mutuality in one's relationships.

Construct validity shows significant positive correlations with measures of social support, relationship satisfaction, and cohesion (Genero, et al., 1992). Also, initial studies showed high inter-item reliability coefficients ranging from 0.89 to 0.92 (Genero, et al., 1992) reported a Cronbach's alpha coefficient of 0.94. Cronbach's Alpha Coefficient obtained for the current study sample was .91

Sample

The sample consist of 118 adults who report a history of abuse as children. This sample size was determined using (Cohen, 1988) formula for calculating sample size in behavioral science. Cohen's formula uses desired significance levels, desired effect size, desired power, number of variables, and statistical tests to determine desired sample size. The proposed sample size was determined based on a significance level of 0.01, a medium effect size of 0.15 (as recommended by Cohen), and a desired power of 0.85 for

a regression analysis with four independent variables. Specifically, the formula

suggested by Cohen calculates N as a function of the unknown Lambda value divided by

the effect size. The unknown Lambda value of 16.1 was calculated from table 9.4.2

(Cohen, 1988) using an estimated sample of 120.

Participants were recruited from the general community through flyers posted in

public areas, social service agencies and waiting rooms of physician and therapist's

offices.   The sample was a non-probability, self-selected sample.

Procedure

Interested participants called an unlisted phone number. A voicemail asked for

their name, phone number and permission to leave a message. The investigator returned

the call, provided a short explanation of the research and asked about their interest in

participating. For those participants who express interest in participating, the Investigator

set up an appointment in a private office.

Upon arrival, participants were presented with an informed consent form

(Appendix VII). Once they have signed the consent form the investigator provided them

with a copy. The consent form includes information about the study, privacy and

confidentiality procedures and procedure for obtaining information about the results of

the study and was approved by the Institutional Review Board. Participants were

presented with the study package and left to complete the study forms.

Following the completion of the study package, the Investigator met with

participants for a short discussion. The investigator presented general information

regarding the possible reaction to trauma, assessed general safety, and provided the

participants with a list of local therapists. Participants were also given the phone number of the county's crisis response team.

Security and Confidentiality

The investigator is a licensed psychologist in Pennsylvania. None of the clients treated by the investigator or by any other therapist in the clinic where the investigator practices currently or during the last five years were recruited or allowed to participate in the study.

The signed informed consent form and the completed study package were assigned a three-digit number. When participants sign the informed consent, the form was separated from the rest of the study package before the rest of the package was given to the participant for completion. Prior to collecting the completed package from participants, the informed consent containing participant's identifying information was placed in a letter size envelope. On the outside of the envelope the investigator recorded the participant's first name and the initials of their middle and last name and the assigned study number.

This information allows the investigator the opportunity to locate the appropriate study package in the event that a participant wanted to withdraw from the study before the study was completed. The envelope was then filed. The file containing the signed informed consent forms will be mailed to the Rutgers University location and filed in the office of the dissertation advisor Dr. Robin Eubanks at Rutgers University. A copy of the form will be filed in a drawer in a locked file cabinet that will be kept in a locked file room. This double lock location meets state and federal regulations for keeping

confidential information such as protected health information under the Health Insurance

Portability and Accountability Act (HIPAA) regulations.

From that moment on only the study package containing the study measures was

handled by the investigator. The informed consent remained in the assigned location

until the study is completed. The individual folders will only be accessed in the event

that the participant wishes to withdraw from the study prior to the study being completed.

The study package was copied. The originals were mailed to the Rutgers

University location and filed in the office of the dissertation advisor Dr. Robin Eubanks

at Rutgers University. The copy is kept in a separate file using the same security

procedures used to safeguard the informed consent forms. After the data was coded and

inputted into a spreadsheet, the study package was stored in the double locked file until

after the completion of the study. Following the completion of the study the data was

stored in a secure, double locked file. The data will remain locked for seven years and

then destroyed.

Data Analysis

The analysis of the data was conducted in four general stages. First the data was

pre-screened for missing data, outliers, normality, and homoscedasticity. Following the

pre-screening, the first stage of the analysis calculated descriptive statistics for each one

of the variables.

To evaluate the first three hypotheses, the second stage of the analysis employed a

Factorial-Multivariate Analysis of Variance (Factorial MANOVA) in order to explore the

differences between gender (male, female) and race/ethnicity (Caucasian, African-American, Latino, and Other) on perceived mutuality, trauma symptoms, and resilience.

The third stage of the analysis employed two separate multiple regression analysis to explore predictive value of mutuality, gender and race/ethnicity, on two resilience variables: resilience as measured by the Resilience Scale for Adults and negative effects of trauma as measured by the Trauma Symptoms inventory.

Chapter 4: Results

The sample was made up of 118 adults who self-reported histories of childhood abuse. Forty-nine identified themselves as male and 69 as females. Seven identified themselves as African-American, 23 as Latino, 72 as Caucasian, and 11 Middle Easterns. Table I provides a demographic description of the sample.

Table 1

Sample Demographic

Demographic	N	Percentage
Total:	118	
Gender:		
Male	49	41.5
Female	69	58.5
Race/ethnicity:		
African American	7	5.9
Latino	23	19.5
White	72	61
Asian	4	3.4
Middle Eastern	11	9.3
Other	1	.8

Four of the 118 cases identified their race/ethnicity as Asian and one identified their race/ethnicity as other. Because of their limited numbers, these cases were removed from the sample, leaving a total sample of 113.

Prior to the analysis, race/ethnicity, gender, perceived mutuality, trauma symptoms and resilience were examined for accuracy of data entry, missing values, and fit between their distributions and the assumptions of multivariate statistics. There were no missing values for any of the variables. No cases were identified as univariate outliers. Also, using Manalanobis distance with $p < .001$, no cases were identified as multivariate outliers.

Skewness and Kurtosis analysis four that the perceived mutuality scale and the trauma symptoms scores were not normally distributed. A square root transformation was performed on these variables. The resulting variables improved the normal distribution of the data and were used for the data analysis. See table 2. The scales were also analyzed for multivariate normality. The scores suggest that data is normally distributed within each group based on gender and race/ethnicity. A visual inspection of scatterplots was used to assess multivariate liminality. Although this is a subjective method, it is the recommended method of analysis for multivariate liminality (Tabachnick & Fidell, 2001; Norman & Streiner, 2000; Mertler & Vannatta, 2013). The analysis suggest a lineal relationship among all dependent and independent variables.

Box's test of equality of covariance matrices was used to test the null hypothesis that the observed covariance matrices of all the dependent variables are equal across groups. Results ($F= 1.330$, $p= .207$) confirms the equality of covariance.

Table 2

Kurtosis and Skewness Scores for Perceived Mutuality and Trauma Symptoms

	Perceived Mutuality	Trauma Symptoms
Skewness		
Original data	.641	1.093
Transformed data	.396	-.079
Kurtosis		
Original Data	.415	.965
Transformed data	.021	-.153

A two-way Multivariate Analysis of Variance was conducted to determine the effect of gender and race/ethnicity on the three dependent variables of perceived mutuality, level of resilience, and trauma symptoms. Resiliency scores and trauma symptoms scales were transformed using a square root method to enhance normality. MANOVA results indicate that Race/ethnicity (Wilks A = .840, F (9, 250) = 2.04, p < .05, N2 = .06) significantly affect the combined dependent variable of perceived mutuality, resilience and trauma symptoms. However, effect size was very small. Gender (Wilks A = .950, F (3, 103) = 1.82, p = .148, N2 = .05) did not significantly affect the combined dependent variable of perceived mutuality, resilience and trauma symptoms.

The interaction between gender and race/ethnicity (Wilks A = .939, F (9, 250) = .725, p = .686) also did not significantly affect the combined dependent variable of perceived mutuality, resilience and trauma symptoms.

Univariate ANOVA and Scheffe post hoc test were conducted as follow-up test. ANOVA results indicate that perceived mutuality significantly differs for race/ethnicity (F (3, 103) = 5.34, p < .05, N2 = .132). Again, effect size was very small.

Scheffe post hoc results for race/ethnicity indicate that Latinos significantly differ from Whites and Middle Easterns. Table 3 presents the group means for gender and race/ethnicity.

Table 3

Adjusted and Unadjusted Group Means

	Resilience		Trauma Symptoms		Perceived Mutuality	
	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted
Gender						
Male	194.85	184.04	9.1	12.12	68.9	72.76
Female	180.76	178.03	16.16	16.45	75.08	75.33
Race/ethnicity						
African American	204.58	185.71	9.83	16.86	69.08	77.0
Latino	179.73	177.74	16.36	16.74	81.6	81.48
Caucasian	180.42	180.28	14.27	14.38	73.16	73.18
Middle Eastern	186.48	185.82	10.01	9.91	64.12	64.00

A multiple regression analysis was conducted to determine which independent variable (perceived mutuality, race/ethnicity and gender) were predictors of trauma symptoms. Gender was coded as dummy variables (0,1) in order to be used in a multiple regression. Each level of race/ethnicity was also coded as a dummy variable. Regression results indicate that none of the variables significantly predicted trauma symptoms. A summary of the regression model is presented in table V. In addition, bivariate and partial correlation coefficients between each predictor and dependent variable are presented in table 4.

A multiple regression analysis was conducted to determine which independent variable (perceived mutuality, race/ethnicity, and gender) were predictors of resilience. Again, gender was coded as dummy variables (0,1) in order to be used in a multiple regression. Every level of race/ethnicity was also coded as a dummy variable. Regression results indicate that none of the entered variables significantly predicted trauma symptoms. A summary of the regression model is presented in table 5. In addition, bivariate and partial correlation coefficients between each predictor and dependent variable are also presented in table 5.

Table 4

Coefficients for Model Variables with Trauma Symptoms as the Dependent Variable

	B	*B*	t	P	Bivariate r	Partial r
Perceived Mutuality	.261	.122	1.55	.124	.105	.144
Resilience	-.026	-.522	-6.70	.000	-.531	-.533
Gender	.503	.151	.1.909	.059	.202	.177

Race/ethnicity	.173	.050	.642	.522	.041	.060

Table 5

Coefficients for Model Variables with Resilience as the Dependent Variable

	B	*B*	t	P	Bivariate r	Partial r
Perceived Mutuality	4.76	.110	1.37	.174	.056	.128
Trauma Symptoms	-10.98	-.544	-6.70	.000	-.531	-.533
Gender	.782	.012	.142	.888	-.084	.013
Race/ethnicity	-.806	-.012	-.145	.885	-.048	-.14

Chapter 5: Discussion

The current study examined the theory proposed by relational-cultural theory regarding the relationship between mutuality and resilience. The researcher hypothesized that there would be a significant difference between men and women on measures of perceived mutuality, resilience and trauma-related symptoms. Results did not supported this hypothesis. In the current study, gender (Wilks $A = .950$, $F (3, 103) = 1.82$, $p = .148$, $N2 = .05$) did not significantly affect the combined dependent variable of perceived mutuality, resilience and trauma symptoms.

The researcher also hypothesized that there would be a significant difference in measures of perceived mutuality, resilience and trauma-related symptoms between members of different ethnic/racial groups. Race/ethnicity (Wilks $A = .840$, $F (9, 250) = 2.04$, $p < .05$, $N2 = .06$) significantly affected the combined dependent variable of perceived mutuality, resilience and trauma symptoms. However, effect size (.06) was very small. Our study showed that the scores for Latinos on the measure of perceived mutuality was significantly higher that the similar score for Caucasians and Middle Eastern.

Related to gender and race/ethnicity, the researcher hypothesized that there would be a significant difference between categories of gender and race/ethnicity on measures of perceived mutuality, resilience, and trauma-related symptoms. This hypothesis was not supported by the results. The combined categories of gender and race/ethnicity yield no statistically significant differences on scores of perceived mutuality, resilience, or trauma-related symptoms. The interaction between gender and race/ethnicity (Wilks $A =$

66

.939, F (9, 250) = .725, p = .686) did not significantly affect the combined dependent variable of Perceived Mutuality, Resilience and trauma symptoms.

The current study examined the theory proposed by relational-cultural theory regarding the relationship between mutuality and resilience. The researcher hypothesized that perceived mutuality, gender, and race/ethnicity will predict resilience. Regression results indicate that none of the variables significantly predicted resilience.

The researcher also hypothesized that mutuality, gender, and race/ethnicity will predict reported symptoms of trauma. Regression results indicate that none of the variables significantly predicted trauma symptoms. Overall, only one of the hypothesis, related to Ethnic/racial differences in the scores of perceived mutuality, trauma symptoms and resilience was supported by the results.

Mutuality, characterized by mutual empathy and mutual empowerment is identified by RCT as the road to recovery from the negative effects of trauma. As discussed earlier, RCT argues that the main cause of human suffering is disconnection and disconnection is healed through new, growth-fostering connections characterized by mutuality. The researcher expected that adults who have histories of abuse and are currently not suffering from all of the negative effects associated with child abuse would have experienced growth-fostering relationships characterized by mutuality at some point in their healing process. If this is the case, then mutuality would be a predictor of resilience and higher scores on the measure of perceived mutuality will predict higher scores on the measure of resilience. That was not the case.

There are several possible explanations for the findings of this study. The most obvious is that the relationship between mutuality and resilience is weak. Although this can be possible, we need to consider other possible explanations as well as the limitations of the current study.

The relationship between mutuality and resilience may be mediated by factors that were not controlled for in the current study. As mentioned earlier, the research on mutuality is limited. The few studies that have attempted to explore protective relational factors for those who experienced trauma appear to suggest that perceived mutuality or similar constructs play a role in resilience. For example, research has found that social support serves as a protective factor against the negative effects of trauma under specific conditions. However, the protective capacity of social support is mediated by type and severity of the traumatic experience, timing and type of support and source of support. In a similar way, the protective or curative effects of mutuality for individuals who have experienced trauma may also be mediated by similar variables and the relationship between these two constructs may only be understood when those variables are controlled. For mutuality, timing of the relationship, other participants in the relationship and age of the person in the relationship may be variables to explore. Some of the few studies on mutuality that have shown positive results focused on specific relationships and had a younger sample made up of adolescents or college students (Neff, Brabeck, & Kearney, 2006; Baumann, Kuhlberg, & Zayas, 2010).

Another possible explanation is that the healing process is unique to each individual. Other research suggest multiple factors that can contribute to the healing

68

process and survivors develop individualized ways of overcoming their trauma (Singh, Garnett, and Williams, 2012; Marriott, Hamilton-Giachritsis, Harrop, 2013; Musliner, 2014; Howell and Miller-Graff, 2014; Coan, Kasle, Jackson, Schaefer, & Davidson, 2013; Chamberland, Lacharite, Clement, & Lessard, 2014; Lamis, Wilson, King, and Kaslow, 2014; Dang, 2014). Resilient individuals find combinations of those factors that facilitate healing. Mutuality may be among that list of factors that may facilitate healing for resilient individuals who experienced abuse, but not the only factor.

The study did find significant difference in the perceive mutuality scores among different ethnic/racial groups. Latinos in our sample scored significantly higher on the measure of perceived mutuality than did Whites or Middle Easterns. In and of itself this results support no conclusions. The number of Middle Easterns in the study was small and the diversity within each category of race/ethnicity is large. The current study does not represent the diverse Ethnic/racial groups.

On the other hand, the difference in scores for perceived mutuality among ethnic/racial groups point to the need for exploring more specific characteristics related to the diversity within the groups and how those characteristics may impact responses to trauma, development and use of relational skills, and resilience.

The need and urgency for the proposed research on diversity and resilience are clear when we consider the increase diversification of the population in the United States. Let's take for example two of the ethnic/racial group classifications in the present study. The Latino population in the United States is large and diverse. As of 2013, there are an estimated 54 million Hispanic people in the United States. That is just over 17% of the

total U.S. population and a 2.1% increase over the previous year; which makes Latinos the largest minority group in the United States. By 2060, the Census Bureau projects that there will be almost 128.8 million Latinos in the United States comprising 31% of the total population.

The numbers alone can be deceiving because they suggest that Latinos and other large group classifications, are one homogeneous group. Two-thirds of Latinos in the United States are of Mexican background. Puerto Ricans make up the second largest group of Latinos in the US with about 9.5%, followed by Salvadorians, with 3.8 % and Cubans with 3.6%. In addition to the size of the population, these groups differ in their relationship to the United States, religious background, cultural practices, ancestry, level of education and many other areas. Also, diversity extends even within the subgroups. For example, there is a significant difference between Puerto Ricans from the Island and Puerto Ricans from New York (Nuyorican). There is also big differences between individuals of Mexican background who have lived in the United States since before the southwest was part of the country and new Mexican immigrants or even Mexican immigrants settling in northern California and those settling in southern California.

There are similar differences with the groups classified as Middle Easterns. According to the Migration Policy Institute, there were 2 million Meddle Eastern and North Africans residing in the United States in 2011. Nearly half of these were Iraqis, Egyptians or Lebanese. As with Latinos, their involvement with the United Sates, their religion and cultural practices are diverse.

The results of the present study suggest that there are differences in perceived mutuality among these groups. However, rather than supporting specific conclusions, the

70

results highlight the need for research to explore the diversity within these groups and the interaction between specific group characteristics and their responses to trauma.

Limitations

The findings of this study need to be understood as exploratory. Given that this is a retrospective study and based on self-report measures, participant's current situation may impact their perception of past events. It is possible that participant would select recent or more intense relationships rather than the ones that most influence their healing process. For example, for our young sample, current romantic relationships, recent changes in their relationship with their parents or recent conflicts within their relationships may have influence their perception of those relationships and the level of mutuality in the relationships. Also, in reporting symptoms of trauma, participants may be influence by current symptoms and may ignore other recent difficulties. Even without the presence of specific stressors, there are significant biases and inaccuracies in how participants remember previous experiences, especially those participant who have experience trauma. This memory bias (Vrijsen et al. 2015) is believe to contribute to the tendency to evaluate one's situation or experiences in a negative light (King et al. 2015). As a result, participants in this study may have interpreted their experiences more negatively, evaluated their level of resilience more negatively or over-reported symptoms of trauma.

The very nature of resilience is a limitation for our study. Resilience refers to competent functioning at a point in time. Research on resilience suggest that resilience changes based on time and situation. Also, the factors that affect resilience at one point in

life may change and become more are less beneficial. As such, interpretations beyond the specific circumstances of the study sample at the time of the study need to be done with caution. That inference can be impacted by a recent failure or a recent success. As such, the scores may be more the result of their recent experiences rather than their pattern of behavior. As is the case with most studies that use a self-report method for data collection, a more objective method may have been preferred. However, such method was not possible for this study.

Using the proposed sampling method will present two significant limitations. First, the sample is a non-probability sample which suggests that it is not representative of the population. For example, although the Ethnic/racial breakdown of the sample may represent the population in central Pennsylvania, it does not represent the ethnic/racial breakdown of the national population. Individuals of Latino and African American heritage are significantly underrepresented in the sample when compare to the population of the United States. Furthermore, the definition of ethnicity and race presents a significant challenge. As currently defined by the US Census Bureau, Latinos are an ethnic group not a racial group. All others such as White, African Americans, and Asians are classified as racial groups. The researcher made a deliberate decision to compare these groups and add the classification of Middle Eastern based on census proposals that were at the experimental stage at the time of the data collection. Future researchers may choose to address this comparison differently.

Second, being a self-selected sample resulting from a general recruitment effort suggests that those who responded have certain characteristics that may not be present in

the population. For example, the level of education in the sample is higher than that found in the general population. Although a different sampling method is desired, it is not possible.

The scope of this project does not allow for other sampling methods. As a result, the researcher is limited in the ability to make inferences about the population based on the results from this study. However, such limitations are common in social science research and do not suggest that the results of the study are useless.

Treatment and Policy Implications:

One of the goals of this this study was to explore the relationship between perceived mutuality and resilience. The expectation was that if mutuality resulted to predict resilience, then enhancing mutuality in relationships may enhance resilient outcomes for children who experienced trauma. The results of the study moves us in a different direction. Until mutuality, or any other factor is proven to be uniquely effective in protecting children from trauma, we need to provide children with a variety of possible experiences to allow them to develop a unique respond to their traumatic situation. For now, social support, relationships with positive people and organizations, access to empirically validated treatment models, alternative treatment experiences (recreational therapy, animal-assisted therapy), opportunities to help others, and other experiences need to continue to be part of the repertoire of intervention available.

Future Research

The recent emphasis in the mental health field towards empirically supported treatment requires RCT as well as any other new therapeutic approach to explore, test and

prove the effectiveness of their interventions. In a similar way, the assumptions made by

RCT such as the role of mutuality in healing, need to be further explored, tested and

proven. Also in need of empirically support is the effectiveness of the treatment modality.

The results of the current study cast doubts on the on the role of mutuality on the

healing process as proposed by the RCT. However, more comprehensive studies that

would include greater diversity in age, diversity and socio-economic status are needed.

Also, rarely does one single factor account for a process of healing. Research that

explores the way mutuality interacts with other factors such as social support or

spirituality is also needed.

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Appendix I: Demographic Information Form

Demographic Information Form

   The following are a few questions about your background. Please remember your answers will be kept anonymous and confidential.

1. Sex: Female _____ Male _____ Transgender _____

2. Age: _____

3. What is/are your ethnic group(s)? (Check all that apply):
   _____ Black or African American
   _____ Latina/o or Hispanic
   _____ White or European American
   _____ Asian/Pacific Island American
   _____ Native American
   _____ Middle Eastern American
   _____ Other (please specify) _____

4. How do you identify yourself racially? _____

5. Relationship status:
   _____ Single, never married
   _____ Married/partnered/living as married
   _____ Divorced
   _____ Separated
   _____ Widowed
   _____ Other

6. What is the highest level of education you have completed?
   _____ Elementary School
   _____ Middle School
   _____ Some High School
   _____ High School
   _____ Associates degree
   _____ Bachelor's degree
   _____ Master's degree
   _____ Doctorate or Professional degree (e.g., MD, PhD, JD, DDS, etc)

7. How would you classify your experience of abuse? (Choose as many as appropriate)

      _____   Physical

      _____   Sexual

      _____   Emotional

      _____   Neglect

      _____   Other

Appendix II: Resilience Scale for Adults

Resilience Scale for Adults

Please think of how you usually are, or how you have been the last month, how you think and feel about yourself, and about important people surrounding you. Please check the option box that is closest to the end statement that describes you best.
© Developed by Odin Hjemdal & Oddgeir Friborg

Name: _____   Todays date: _____

Age: _____   Gender: _____ female/male

1. When something unforeseen happens	I often feel bewildered	☐ ☐ ☐ ☐ ☐ ☐ ☐	I always find a solution
2. My plans for the future are	difficult to accomplish	☐ ☐ ☐ ☐ ☐ ☐ ☐	possible to accomplish
3. I enjoy being	together with other people	☐ ☐ ☐ ☐ ☐ ☐ ☐	by myself
4. My family's understanding of what is important in life is	quite different	☐ ☐ ☐ ☐ ☐ ☐ ☐	very similar
5. I can discuss personal issues with	no one	☐ ☐ ☐ ☐ ☐ ☐ ☐	friends/family-members
6. I am at my best when I	have a goal to strive for	☐ ☐ ☐ ☐ ☐ ☐ ☐	can take one day at a time
7. My personal problems	I know how to solve	☐ ☐ ☐ ☐ ☐ ☐ ☐	I can not find any solutions for
8. I feel that my future looks	very promising	☐ ☐ ☐ ☐ ☐ ☐ ☐	uncertain
9. To be flexible in social settings	is not important to me	☐ ☐ ☐ ☐ ☐ ☐ ☐	is really important to me
10. I feel	very happy with my family	☐ ☐ ☐ ☐ ☐ ☐ ☐	very unhappy with my family
11. Those who are good at encouraging me are	some close friends/family members	☐ ☐ ☐ ☐ ☐ ☐ ☐	no one
12. When I start on new things/projects	I rarely plan ahead, just get on with it	☐ ☐ ☐ ☐ ☐ ☐ ☐	I prefer to have a plan
13. My judgements and decisions	I often doubt	☐ ☐ ☐ ☐ ☐ ☐ ☐	I trust completely
14. My goals	I know how to accomplish	☐ ☐ ☐ ☐ ☐ ☐ ☐	I am unsure how to accomplish
15. New friendships are something	I make easily	☐ ☐ ☐ ☐ ☐ ☐ ☐	I have difficulty making
16. My family is characterized by	disconnection	☐ ☐ ☐ ☐ ☐ ☐ ☐	healthy cohesion
17. The bonds among my friends is	weak	☐ ☐ ☐ ☐ ☐ ☐ ☐	strong
18. I am good at	organizing my time	☐ ☐ ☐ ☐ ☐ ☐ ☐	wasting my time
19. Belief in myself	gets me through difficult periods	☐ ☐ ☐ ☐ ☐ ☐ ☐	is of little help in difficult periods
20. My goals for the future are	unclear	☐ ☐ ☐ ☐ ☐ ☐ ☐	well thought through
21. Meeting new people is	difficult for me	☐ ☐ ☐ ☐ ☐ ☐ ☐	something I am good at

89

22. In difficult periods my family	keeps a positive outlook on the future	☐	☐	☐	☐	☐	☐	☐	views the future as gloomy
23. When a family member experiences a crisis/emergency	I am informed right away	☐	☐	☐	☐	☐	☐	☐	it takes quite a while before I am told
24. Rules and regular routines	are absent in my everyday life	☐	☐	☐	☐	☐	☐	☐	are a part of my everyday life
25. In difficult periods I have a tendency to	view everything gloomily	☐	☐	☐	☐	☐	☐	☐	find something good that help me thrive/ prosper
26. When I am with others	I easily laugh	☐	☐	☐	☐	☐	☐	☐	I seldom laugh
27. Facing other people, our family acts	unsupportive of one another	☐	☐	☐	☐	☐	☐	☐	loyally towards one another
28. I get support from	friends/ family members	☐	☐	☐	☐	☐	☐	☐	no one
29. Events in my life that I cannot influence	I manage to come to terms with	☐	☐	☐	☐	☐	☐	☐	are a constant source of worry/concern
30. For me, thinking of good topics for conversation is	difficult	☐	☐	☐	☐	☐	☐	☐	easy
31. In my family we like to	do things together	☐	☐	☐	☐	☐	☐	☐	do things on our own
32. When needed, I have	no one who can help me	☐	☐	☐	☐	☐	☐	☐	always someone who can help me
33. My close friends/ family members	appreciate my qualities	☐	☐	☐	☐	☐	☐	☐	dislike my qualities

Appendix III: Trauma Symptoms Checklist

Trauma Symptoms Checklist (TSC-40)

How often have you experienced each of the following in the last two months?

0 = Never, 3 = Often

1. Headaches   0 1 2 3

2. Insomnia (trouble getting to sleep)   0 1 2 3

3. Weight loss (without dieting)   0 1 2 3

4. Stomach problems   0 1 2 3

5. Sexual problems   0 1 2 3

6. Feeling isolated from others   0 1 2 3

7. "Flashbacks" (sudden, vivid, distracting memories)   0 1 2 3

8. Restless sleep   0 1 2 3

9. Low sex drive   0 1 2 3

10. Anxiety attacks   0 1 2 3

11. Sexual overactivity   0 1 2 3

12. Loneliness   0 1 2 3

13. Nightmares   0 1 2 3

14. "Spacing out" (going away in your mind)   0 1 2 3

15. Sadness   0 1 2 3

16. Dizziness   0 1 2 3

17. Not feeling satisfied with your sex life   0 1 2 3

18. Trouble controlling your temper   0 1 2 3

19. Waking up early in the morning and can't get back to sleep   0 1 2 3

20. Uncontrollable crying   0 1 2 3

21. Fear of men   0 1 2 3

22. Not feeling rested in the morning   0 1 2 3

23. Having sex that you didn't enjoy   0 1 2 3

24. Trouble getting along with others   0 1 2 3

25. Memory problems   0 1 2 3

26. Desire to physically hurt yourself   0 1 2 3

27. Fear of women   0 1 2 3

28. Waking up in the middle of the night   0 1 2 3

29. Bad thoughts or feelings during sex   0 1 2 3

30. Passing out   0 1 2 3

31. Feeling that things are "unreal"   0 1 2 3

32. Unnecessary or over-frequent washing   0 1 2 3

33. Feelings of inferiority   0 1 2 3

34. Feeling tense all the time   0 1 2 3

35. Being confused about your sexual feelings   0 1 2 3

36. Desire to physically hurt others   0 1 2 3

37. Feelings of guilt   0 1 2 3

38. Feelings that you are not always in your body   0 1 2 3

39. Having trouble breathing   0 1 2 3

40. Sexual feelings when you shouldn't have them   0 1 2 3

Appendix IV: Mutual Psychological Development Questionnaire (MPDQ)

The Mutual Psychological Development Questionnaire

We would like you to tell us about a relationship.

If married how many years? _____
What is your spouse's age? _____
How long have you known the other person in this relationship? _____
What is this person's age?_____

Are you currently living with this person? ____ Yes ____ No

In this section we would like to explore certain aspects of your relationship. Using the scale below, please tell us your best estimate of how often you and your relationship partner experience each of the following:

1= Never   3= Occasionally   5= Most of the time
2= Rarely   4= More Often Than Not   6= All the time

When we talk about things that matter to my partner, I am likely to …

Be receptive	1	2	3	4	5	6
Get impatient	1	2	3	4	5	6
Try to understand	1	2	3	4	5	6
Get bored	1	2	3	4	5	6
Feel moved	1	2	3	4	5	6
Avoid being honest	1	2	3	4	5	6
Be open-minded	1	2	3	4	5	6
Get discouraged	1	2	3	4	5	6
Get involved	1	2	3	4	5	6
Have difficulty listening	1	2	3	4	5	6
Feel energized by our conversation	1	2	3	4	5	6

When we talk about things that matter to me, my partner is likely to …

Pick up on my feelings	1	2	3	4	5	6
Feel like we are not getting anywhere	1	2	3	4	5	6
Show an interest	1	2	3	4	5	6
Get frustrated	1	2	3	4	5	6
Share similar experiences	1	2	3	4	5	6
Keep feeling inside	1	2	3	4	5	6
Respect my point of view	1	2	3	4	5	6
Change the subject	1	2	3	4	5	6
See the humor in things	1	2	3	4	5	6
Feel down	1	2	3	4	5	6
Express an opinion clearly	1	2	3	4	5	6

Appendix V: Recruitment Letter/Flyer
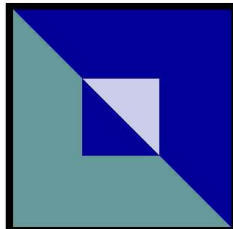
Study Participant Needed

The study will investigate the relationship between resilience and relationships.

We are seeking participants who are adults between the ages of 18 and 65 with histories of childhood abuse. Participants will be asked to meet with the researcher in a confidential setting and complete several questioners that explore their perception of relationships. Participants will also be asked about their current level of functioning and about psychological symptoms.

Time Commitment: One to onre and a half hours

Benefits: Participants will contribute to the understanding of the healing process for victims of childhood abuse.

Participants who complete the study will receive a $10 Starbucks gift card as appreciation for their participa-

For more information Contact
Carlos F. Pozzi
717-645-7680

Appendix VI: Consent

UMDNJ

SCHOOL OF HEALTH
RELATED PROFESSIONS

University of Medicine & Dentistry of New Jersey

Department of Interdisciplinary Studies
Health Sciences Program

Consent to Participate in Research

You are being asked to participate in a research study. Before you agree, the investigator must tell you about (i) the purposes, procedures, and duration of the research; (ii) any procedures which are experimental; (iii) any reasonably foreseeable risks, discomforts, and benefits of the research; (iv) any potentially beneficial alternative procedures or treatments; and (v) how confidentiality will be maintained.

Where applicable, the investigator must also tell you about (i) any available compensation or medical treatment if injury occurs; (ii) the possibility of unforeseeable risks; (iii) circumstances when the investigator may halt your participation; (iv) any added costs to you; (v) what happens if you decide to stop participating; (vi) when you will be told about new findings which may affect your willingness to participate; and (vii) how many people will be in the study.

If you agree to participate, you must be given a signed copy of this document and a written summary of the research.

You may contact Carlos F. Pozzi at 717-671-7874 any time you have questions about the research.

You may contact the IRB Director at (973)-972-3608 Newark if you have questions about your rights as a research subject or what to do if you are injured.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop.

Signing this document means that the research study, including the above information, has been described to you orally, and that you voluntarily agree to participate.

_____   _____
signature of participant   date

_____   _____
signature of witness   date